2022 Community Health Needs Assessment

UC DAVIS HEALTH | MEDICAL CENTER

2022 Community Health Needs Assessment

Conducted on behalf of

UC Davis Health

UC Davis Medical Center
2315 Stockton Blvd.
Sacramento, CA 95817

Conducted by

January 2022

UC DAVIS HEALTH | MEDICAL CENTER

Acknowledgements from Community Health Insights

We are deeply grateful to all those who contributed to this community health needs assessment. Many dedicated healthcare practitioners, community health experts and members of various social service organizations serving the most vulnerable members of the Sacramento County community gave their time and expertise as key informants and survey respondents to help guide and inform the findings of the assessment. Specific survey respondents that expressed a desire to be recognized in the report are listed in the technical section of the report in the Community Service Provider Survey section. Many community residents also participated and volunteered their time to tell us what it is like to live in the community and shared the challenges they face trying to achieve better health.

We also appreciate the collaborative spirit of Kaiser Permanente and their willingness to share the information they gathered while conducting a similar health assessment in the Sacramento area. Last, we especially acknowledge the sponsors of this assessment, Dignity Health, Sutter Health, and UC Davis Health, who, using the results of these assessments, continuously work to improve the health of the communities they serve. To everyone who supported this important work, we extend our heartfelt gratitude.

Community Health Insights (www.communityhealthinsights.com) conducted the assessment on behalf of Sacramento County. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. This joint report was authored by:

- Dale Ainsworth, PhD, MSOD, Managing Partner of Community Health Insights and Associate Professor of Public Health at California State University, Sacramento
- Heather Diaz, DrPH, MPH, Managing Partner of Community Health Insights and Professor of Public Health at California State University, Sacramento
- Mathew Schmidtlein, PhD, MS, Managing Partner of Community Health Insights and Professor of Geography at California State University, Sacramento
- Traci Van, Senior Community Impact Specialist of Community Health Insights

Welcome to our 2022 Community Health Needs Assessment

UC Davis Health is proud of the work we do to support the Sacramento region through our mission of clinical care, research and education. We are deeply committed to reducing inequities and health disparities. This is work that we do collaboratively. The community health needs assessment (CHNA) is a unique opportunity for us to partner with other health systems, non-profit organizations, social services, and residents and leaders in public health with the ultimate goal of identifying and prioritizing the significant health needs of our community.

The priorities identified in this report and the needs articulated by the people who contributed to its creation help guide our community benefit activities and initiates to improve community health. Specifically, the Implementation Plan that we develop is our roadmap for the next three years – it will help us better invest our resources and position us to more efficiently and innovatively reduce inequities in healthcare.

This report – and the Impact of Actions section that highlights UC Davis Heath's work to address our community's health needs – focuses on Sacramento County. UC Davis Health's impact extends beyond Sacramento, deep into the 33 counties that make up our catchment area, and well beyond. While not discussed here, many highly dedicated people, clinical activities and research endeavors exist across the health system that touch Northern California residents in profound ways.

I hope that this report engages you and gives you new perspectives on the needs in our communities, while describing the highly meaningful work that you do.

I invite you to read this CHNA report, contemplate the challenges in our communities, and consider assets and opportunities. We encourage you to share your feedback with us at HS-Community.Relations@ucdavis.edu.

David A. Lubarsky, M.D., M.B.A.
Vice Chancellor of Human Health Sciences and CEO
UC Davis Health

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Report Summary

Purpose

The purpose of this community health needs assessment (CHNA) was to identify and prioritize significant health needs of the greater Sacramento area community. The priorities identified in this report help to guide nonprofit hospitals' community health improvement programs and community benefit activities as well as their collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets the requirements of the Patient Protection and Affordable Care Act (and in California, Senate Bill 697) that nonprofit hospitals conduct a community health needs assessment at least once every three years. The CHNA was conducted by Community Health Insights (www.communityhealthinsights.com) and was a collaboration between Dignity Health, Sutter Health, and UC Davis Health. Multiple other community partners collaborated to conduct the CHNA.

Community Definition

The definition of the community served included most portions of Sacramento County and a small portion of western El Dorado County, California. Regarded as a highly diverse community, Sacramento County covers 994 square miles and is home to approximately 1.5 million residents. The CHNA uses this definition of the community served, as this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Assessment Process and Methods

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[1] This model of population health includes many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data-collection and analytic stages were developed. These included the collection and analysis of both primary (qualitative) and secondary (quantitative) data. Qualitative data included one-on-one and group interviews with 87 community health experts, social service providers, and medical personnel. Additionally, 57 community residents or community service provider organizations participated in 11 focus groups across the service area. Finally, 31 community service providers responded to a Community Service Provider (CSP) survey about health need identification and prioritization.

Focusing on social determinants of health to identify and organize secondary data, datasets included measures to describe mortality and morbidity and social and economic factors such as income, educational attainment, and employment. Furthermore, the measures also included indicators to describe health behaviors, clinical care (both quality and access), and the physical environment.

At the time that this CHNA was conducted, the COVID-19 pandemic was impacting communities across the United States, including Sacramento County. The process for conducting the CHNA remained fundamentally the same. However, adjustments were made during the qualitative data collection to ensure the health and safety of those participating. Additionally, COVID-19 data were incorporated into the quantitative data analysis and COVID-19 impact was captured during qualitative data collection. These findings are reported throughout various sections of the report.

Process and Criteria to Identify and Prioritize Significant Health Needs

Primary and secondary data were analyzed to identify and prioritize significant health needs (SHNs). This began by identifying 12 potential health needs (PHNs). These PHNs were compiled from previous CHNAs conducted across Northern California over a period of approximately six years. Data were analyzed to discover which, if any, of the PHNs were present in the service area. After identifying those PHNs that were present as significant health needs, they were prioritized based on rankings provided by primary data sources described above. Qualitative data were also analyzed to detect emerging health needs; that is, a health need that emerged from data analysis beyond those 12 PHNs identified in previous CHNAs. (For detailed accounting of how health needs were identified and ranked see the Technical Section of the 2022 CHNA).

Because of the dynamic and evolving nature of health needs, identified significant health needs change over time and new needs may appear. For this assessment, one new emergent health need was identified: Health Equity: Equal Access to Opportunities to be Healthy (#6). Furthermore, data analysis identified three potential health needs (PHNs) that met the threshold of significance to be included in this assessment that were not identified in the previous assessment conducted in 2019. These were: Increased Community Connections (#9), Access to Dental Care and Preventive Services (#12), and Healthy Physical Environment (#13).

[1]See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

List of Prioritized Significant Health Needs

The following significant health needs identified for Sacramento County are listed below in prioritized order.

1. Access to Mental/Behavioral Health and Substance-Use Services
2. Access to Basic Needs Such as Housing, Jobs, and Food
3. Access to Quality Primary Care Health Services
4. System Navigation
5. Injury and Disease Prevention and Management
6. Health Equity: Equal Access to Opportunities to be Healthy (new, emergent)
7. Active Living and Healthy Eating
8. Safe and Violence-Free Environment
9. Increased Community Connections (new from PHNs)
10. Access to Specialty and Extended Care
11. Access to Functional Needs (transportation and physical mobility)
12. Access to Dental Care and Preventive Services
13. Healthy Physical Environment

Communities of Concern

Communities of Concern are geographic areas in Sacramento County, defined by ZIP Code boundaries, that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Geographic Communities of Concern were identified using a combination of primary and secondary data sources.
For this assessment, 50 ZIP Codes in total were included across all of Sacramento County; of these, 19 met the requirements to be included as a Community of Concern. The total population within these communities was approximately 700,000 residents, representing 44% of the total population in the service area.

Conclusion

This CHNA details the process and findings of a comprehensive community health needs assessment to guide decision-making for the implementation of community health improvement efforts using a health equity lens. The CHNA includes an overall health and social examination of the Sacramento County service area and clearly details the needs of community members living in parts of the service area where the residents experience health disparities. This report also serves as a resource for community organizations in their effort to improve the health and well-being of the communities they serve.

Report Adoption, Availability, and Comments

The Governing Board of UC Davis Medical Center reviewed, approved and adopted this CHNA on May 25, 2022.

This main report and the data and technical section is widely available to the public on the hospital's website at health.ucdavis.edu/aboutus/community-engagement/index.html, and a paper copy is available for inspection upon request at UC Davis Health, Community Integration Department, 4800 2nd Avenue, Suite 2100, Sacramento, CA 95817.

Written comments on this report can be submitted by email to HS-Community.Relations@ucdavis.edu.

Introduction and Purpose

Both state and federal laws require that nonprofit hospitals conduct a community health needs assessment (CHNA) every three years to identify and prioritize the significant health needs of the communities they serve. The results of the CHNA guide the development of implementation plans aimed at addressing identified health needs. Federal regulations define a health need accordingly: "Health needs include requisites for the improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities)" (p. 78963).[2]

This report documents the processes, methods, and findings of a CHNA conducted on behalf of the nonprofit hospitals listed below. Collectively, these nonprofit hospitals serve Sacramento County, California, located in the north-central part of the state. The total population of the service area was 1,564,555 in 2020. The CHNA was conducted over a period of 10 months, beginning in March 2021 and concluding in December 2021. This CHNA report meets requirements of the Patient Protection and Affordable Care Act (and in California, of Senate Bill 697) that nonprofit hospitals conduct a CHNA at least once every three years.

<table>
<tr><th>Dignity Health Affiliates</th><th>Sutter Health Affiliates</th><th>UC Davis Health System</th></tr>
<tr><td>Mercy Hospital of Folsom
1650 Creekside Dr.
Folsom, CA 95630</td><td rowspan="2">Sutter Medical Center, Sacramento
2825 Capitol Ave.
Sacramento, CA 95816</td><td rowspan="4">UC Davis Medical Center
2315 Stockton Blvd.
Sacramento, CA 95817</td></tr>
<tr><td>Mercy San Juan Medical Center
6501 Coyle Ave.
Carmichael, CA 95608</td></tr>
<tr><td>Mercy General Hospital
4001 J St.
Sacramento, CA 95819</td><td rowspan="2">Sutter Center for Psychiatry
7700 Folsom Blvd.
Sacramento, CA 95826</td></tr>
<tr><td>Methodist Hospital of Sacramento
7500 Hospital Dr.
Sacramento, CA 95823</td></tr>
</table>

Community Health Insights (www.communityhealthinsights.com) conducted the CHNA. Community Health Insights is a Sacramento-based research-oriented consulting firm dedicated to improving the health and well-being of communities across Central and Northern California. Community Health Insights has conducted health assessments for healthcare systems and local health departments over the previous decade. For this assessment Community Health Insights collaborated with Harder+Company, a consulting firm working on behalf of Kaiser Permanente to conduct a CHNA in the Sacramento region, by sharing primary data.

Methods Overview

Conceptual and Process Models

The data used to conduct the CHNA were identified and organized using the widely recognized Robert Wood Johnson Foundation's County Health Rankings model.[3] This model of population health includes the many factors that impact and account for individual health and well-being. Furthermore, to guide the overall process of conducting the assessment, a defined set of data collection and analytic stages were developed. For a detailed review of methods, see the technical section.

[2] Federal Register, vol. 79, No. 250, (Wednesday, December 31, 2014). Department of Treasury, Internal Revenue Service.
[3] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

Public Comments from Previously Conducted CHNAs

Regulations require that nonprofit hospitals include written comments from the public on their previously conducted CHNAs and most recently adopted implementation strategies. The 2019 CHNA was made public for UC Davis Medical Center in Sacramento County. The community was invited to provide written comments on the CHNA reports and Implementation Strategies both within the documents and on the web site where they are widely available to the public. The email address of HS-Community.Relations@ucdavis.edu was created to ensure comments were received and responded to. No written comments were received.

Data Used in the CHNA

Data collected and analyzed included both primary (or qualitative data) and secondary (or quantitative data). Primary data included 42 interviews with 87 community health experts, 11 focus groups conducted with a total of 57 community residents or community-facing service providers, and 31 responses to the Community Service Provider survey. (A full listing of all participants can be seen in the technical section of this report.)

Secondary data included multiple datasets selected for use in the various stages of the analysis. A combination of mortality and socioeconomic datasets collected at subcounty levels was used to identify portions of the hospital service area with greater concentrations of disadvantaged populations and poor health outcomes. A set of county-level indicators was collected from various sources to help identify and prioritize significant health needs. Additionally, socioeconomic indicators were collected to help describe the overall social conditions within the service area. Health outcome indicators included measures of both mortality (length of life) and morbidity (quality of life). Health factor indicators included measures of 1) health behaviors, such as diet and exercise and tobacco, alcohol, and drug use; 2) clinical care, including access to quality care; 3) social and economic factors such as race/ethnicity, income, educational attainment, employment, and neighborhood safety; and 4) physical environment measures, such as air and water quality, transit and mobility resources, and housing affordability. In all, 68 different health outcome and health factor indicators were collected for the CHNA.

Data Analysis

Primary and secondary data were analyzed to identify and prioritize the significant health needs within the service area. This included identifying 12 PHNs in these communities. These PHNs were those identified in previously conducted CHNAs. Data were analyzed to discover which, if any, of the PHNs were present in the hospital's service area. After these were identified, health needs were prioritized based on an analysis of primary data sources that described the PHN as a significant health need.

For an in-depth description of the processes and methods used to conduct the CHNA, including primary and secondary data collection, analysis, and results, see the technical section of this report.

Findings – Sacramento County

Prioritized Significant Health Needs–Sacramento County

Primary and secondary data were analyzed to identify and prioritize the significant health needs in the service area. In all, 13 significant health needs were identified. After these were identified, they were prioritized based on an analysis of primary data. The findings are displayed in Figure 1.

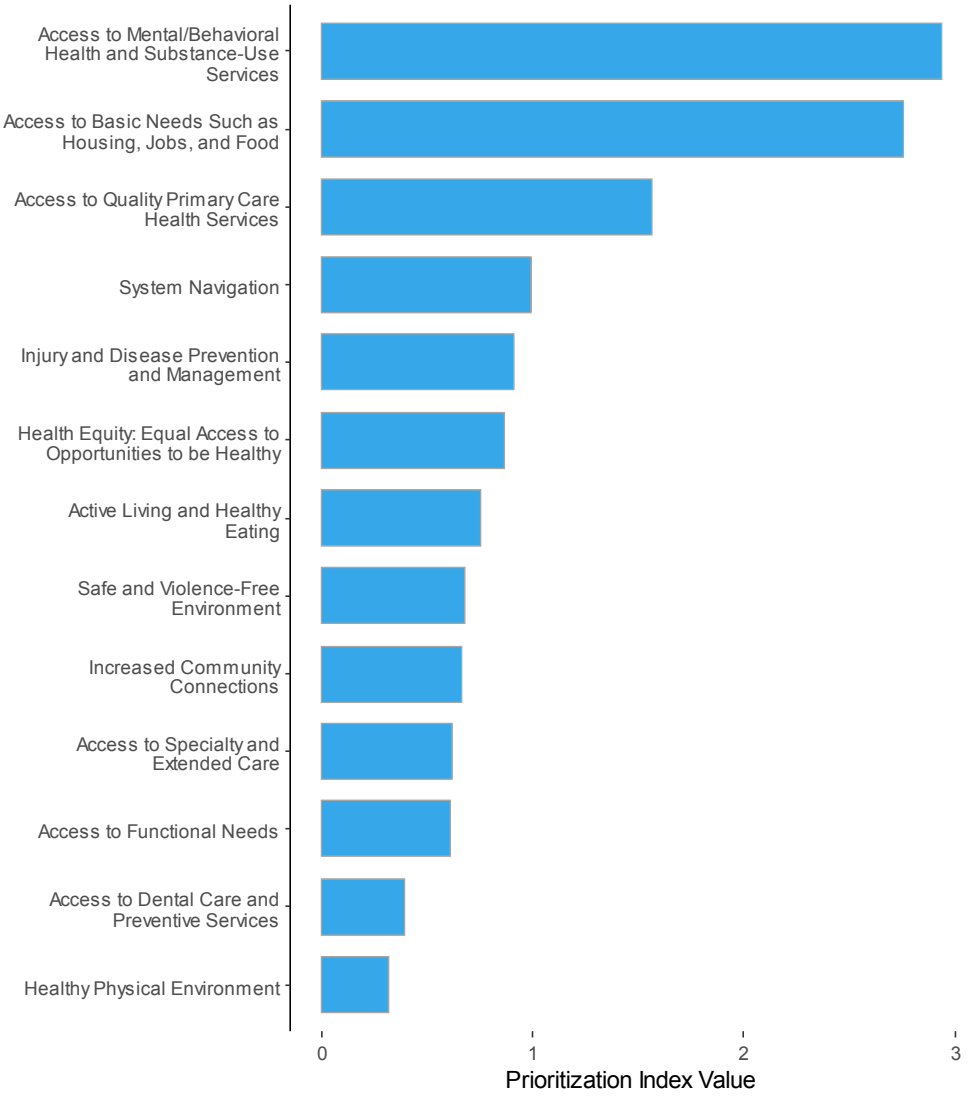
Because of the dynamic and evolving nature of health needs, identified significant health needs change over time. For this assessment, an emergent health need was identified: Health Equity: Equal Access to Opportunities to be Healthy (#6). Furthermore, data analysis identified three significant health needs that were not identified in the previous assessment conducted in 2019. These were: Increased Community Connections (#9), Access to Dental Care and Preventive Services (#12), and Healthy Physical Environment (#13).

Prioritization was based on three measures of community input. The first two measures came from the key informant interview and focus group results. These included the percentage of sources that identified a health need as existing in the community, and the percentage of times the sources identified a health need

as a top priority. The last measure was the percentage of Community Service Provider survey respondents that identified a health need as a top priority. Table 1 shows the values of these measures for each significant health need.

These measures were then combined to create a health need prioritization index. The highest priority was given to health needs that were more frequently mentioned and were more frequently identified among the top priority needs.[4] The prioritization index values are shown in Figure 1, where health needs are ordered from highest priority at the top of the figure to lowest priority at the bottom.

Figure 1: Prioritized, Significant Health Needs for Sacramento County



[4] Additional details regarding the creation of the prioritization index can be found in the technical report.

Table 1: Health need prioritization inputs for Sacramento County

Prioritized Health Needs	% of Key Informants and Focus Groups Identifying Health Need	% of Times Key Informants and Focus Groups Identified Health Need as a Top Priority	% of Community Survey Respondents that Identified Health Need as a Top Priority
Access to Mental/ Behavioral Health and Substance-Use Services	88%	33%	77%
Access to Basic Needs Such as Housing, Jobs, and Food	94%	26%	74%
Access to Quality Primary Care Health Services	72%	12%	32%
System Navigation	53%	4%	23%
Injury and Disease Prevention and Management	69%	4%	3%
Health Equity: Equal Access to Opportunities to be Healthy	69%	4%	~
Active Living and Healthy Eating	50%	4%	6%
Safe and Violence-Free Environment	28%	1%	26%
Increased Community Connections	44%	4%	6%
Access to Specialty and Extended Care	34%	1%	16%
Access to Functional Needs	53%	1%	0%
Access to Dental Care and Preventive Services	19%	2%	10%
Healthy Physical Environment	6%	1%	16%

~ Because this was an emergent health need it was not included as a potential health need; therefore, the Community Service Provider survey did not list this health need as an option for respondents to select.

Health Need Tables Description

The significant health needs are described below, in prioritized order. The secondary data indicators used in the CHNA that performed poorly compared to benchmarks are listed in the table below each significant health need. (Each indicator is listed in the order it appears in the data set listed in the technical report). Qualitative themes that emerged during analysis are also provided in each table. A full listing of all quantitative indicators can be found in the technical section of this report. Secondary indicators that were associated with a health need were assigned to that health need based on expert review. Furthermore, some indictors were assigned to multiple health needs.

1. Access to Mental/Behavioral Health and Substance-Use Services

Individual health and well-being are inseparable from individual mental and emotional outlook. Coping with daily life stressors is challenging for many people, especially when other social, familial, and economic challenges occur. Access to mental, behavioral, and substance-use services is an essential ingredient for a healthy community where residents can obtain additional support when needed.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ There are not enough mental health and substance-use services (treatment centers, detox centers, crisis stabilization units, etc.) in the community.
▪ Additional mental health services are needed specifically for youth, including trauma informed care.
▪ It is difficult to enter and navigate the mental health system.
▪ The stigma around seeking mental health services prevents some from seeking care.
▪ The cost of mental health services is prohibitive; treatment options for those on Medi-Cal are severely limited.
▪ The mental health system is siloed from the healthcare system. Need better integration between these two.
▪ There has been a notable increase in mental health issues in the community due to the pandemic.</td><td>▪ It's difficult for people to navigate for mental, behavioral, and substance-use services.
▪ Additional services for those who are homeless and experiencing mental, behavioral, and/or substance use services are needed.
▪ There aren't enough mental health providers or treatment centers in the area (e.g., psychiatric beds, therapists, support groups).</td><td>▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Suicide Mortality
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Excessive Drinking
▪ Drug-Induced Death
▪ Adult Smoking
▪ Primary Care Shortage Area
▪ Mental Health Care Shortage Area
▪ Medically Underserved Area
▪ Firearm Fatalities Rate
▪ Disconnected Youth</td></tr>
</table>

2. Access to Basic Needs Such as Housing, Jobs, and Food

Access to affordable and clean housing, stable employment, quality education, and adequate food for good health are vital for survival. Maslow's Hierarchy of Needs[5] suggests that only when people have their basic physiological and safety needs met can they become engaged members of society and self-actualize or live to their fullest potential, including enjoying good health. Research shows that the social determinants of health, such as quality housing, adequate employment and income, food security, education, and social support systems, influence individual health as much as health behaviors and access to clinical care.[6]

<table>
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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Housing access and affordability is a critical issue in the area; subsidies and rent control are needed.
▪ Housing vouchers are stigmatized; many landlords will not accept them.
▪ Housing costs continue to escalate; barriers to secure housing continue to rise.
▪ The number of people experiencing homelessness has significantly increased.
▪ The community must address income inequality.
▪ The working poor do not qualify for many services; they are unable to access needed healthcare and mental health services.
▪ More investment is needed in poorer communities.
▪ Many jobs do not pay a living wage, nor do they offer employees health insurance.
▪ Food insecurity is a critical issue for many in the area.</td><td>▪ Lack of affordable housing is a significant issue in the area.
▪ The area needs additional low-income housing options.
▪ Services for homeless residents in the area are insufficient.</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Hypertension Mortality
▪ Diabetes Prevalence
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Drug-Induced Death
▪ Adult Obesity
▪ Limited Access to Healthy Foods
▪ Food Environment Index
▪ Medically Underserved Area
▪ COVID-19 Cumulative Full Vaccination Rate
▪ Disconnected Youth
▪ Third Grade Reading Level
▪ Third Grade Math Level
▪ Children in Single-Parent Households
▪ Children Eligible for Free Lunch
▪ Children in Poverty
▪ Median Household Income</td></tr>
</table>

[5] McLeod, S. 2014. Maslow's Hierarchy of Needs. Retrieved from: http://www.simplypsychology.org/maslow.html

[6] See: http://www.countyhealthrankings.org/learn-others/research-articles#Rankingsrationale

3. Access to Quality Primary Care Health Services

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners and physician assistants, pharmacists, telephone advice nurses, and other similar resources. Primary care services are typically the first point of contact when an individual seeks healthcare. These services are the front line in the prevention and treatment of common diseases and injuries in a community.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ The community needs more providers that accept Medi-Cal.
▪ Community members with high-deductible health plans avoid care as they cannot afford the out-of-pocket costs.
▪ Having health insurance does not guarantee one can access the healthcare system.
▪ The cost of medications creates a barrier for many.
▪ The healthcare system seems to be built to serve more affluent populations; it is difficult for lower income residents to access quality healthcare.
▪ Physicians cannot afford to care for those on Medi-Cal; reimbursement must increase.
▪ A single-payer system is needed to improve access and quality healthcare for all.
▪ There is no comprehensive health plan for the undocumented.</td><td>▪ Patients have difficulty obtaining appointments outside of regular business hours.
▪ Wait times for appointments are excessively long.
▪ Quality health insurance is unaffordable.</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Chronic Lower Respiratory Disease Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Alzheimer's Disease Mortality
▪ Influenza and Pneumonia Mortality
▪ Diabetes Prevalence
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Colorectal Cancer Prevalence
▪ Breast Cancer Prevalence
▪ Lung Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Primary Care Shortage Area
▪ Medically Underserved Area
▪ Preventable Hospitalization
▪ COVID-19 Cumulative Full Vaccination Rate</td></tr>
</table>

4. System Navigation

System navigation refers to an individual's ability to traverse fragmented social services and healthcare systems in order to receive the necessary benefits and supports to improve health outcomes. Research has demonstrated that navigating the complex U.S. healthcare system is a barrier for many that results in health disparities.[7] Furthermore, accessing social services provided by government agencies can be an obstacle for those with limited resources such as transportation access and English proficiency.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ There is too much "red tape" when trying to access social services.
▪ Many community members struggle with how to access and navigate the healthcare system.
▪ The healthcare system is fragmented, making navigation a challenge for many.
▪ System navigation challenges are compounded by language barriers.
▪ There needs to be better linkages between primary and specialty care.
▪ More culturally informed and linguistically appropriate navigators, social workers, and case managers are needed to meet the demand for services.
▪ Systems are particularly challenging for those with mental health and developmental challenges.</td><td>▪ People may not be aware of the services they are eligible for.
▪ It is difficult for people to navigate multiple, different healthcare systems.
▪ Dealing with medical and insurance paperwork can be overwhelming.</td><td>▪ No quantitative indicators were used in analysis for this health need. Currently, there are no indicators available that describe the degree of navigation difficulty for Sacramento County residents.</td></tr>
</table>

[7] Natale-Pereira, A. et. al .2011. *The Role of Patient Navigators in Eliminating Health Disparities*. US National Library of Medicine, National Institutes of Health, 117:15, 3543-3552.

5. Injury and Disease Prevention and Management

Knowledge is important for individual health and well-being, and efforts aimed at injury and disease prevention are powerful vehicles to improve community health. When community residents lack adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Prevention efforts focus on reducing cases of injury and infectious disease control (e.g., sexually transmitted infection (STI) prevention and influenza shots), and intensive strategies in the management of chronic diseases (e.g., diabetes, hypertension, obesity, and heart disease) are important for community health improvement.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th colspan="2">Secondary Data Analysis</th></tr>
<tr><td colspan="2">The manner in which the health need appeared or was expressed in the community was described by key informants, focus group participants, and respondents of the Community Service Provider survey.</td><td colspan="2" rowspan="2">The following indicators performed worse in Sacramento County when compared to state averages.</td></tr>
<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Preventative services have been avoided due to the pandemic.
▪ Health education is critical to prevention, and it's relatively inexpensive.
▪ Community health education must be expanded; move away from reactive care and into prevention.
▪ Health information needs to be linguistically appropriate.
▪ The community must increase access to preventative healthcare screenings.</td><td>▪ There isn't really a focus on prevention around here.
▪ There should be greater focus on chronic disease prevention (e.g., diabetes, heart disease).
▪ Patients need to be better connected to service providers (e.g., case management, patient navigation, or centralized service provision).
▪ Prevention efforts need to be focused on specific populations in the community (e.g., youth, Spanish-speaking residents, elderly, LGBTQ individuals, and immigrants).</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Stroke Mortality
▪ Chronic Lower Respiratory Disease Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Suicide Mortality
▪ Unintentional Injuries Mortality
▪ Alzheimer's Disease Mortality
▪ Diabetes Prevalence
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Frequent Physical Distress</td><td>▪ Poor or Fair Health
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Excessive Drinking
▪ Drug-Induced Death
▪ Adult Obesity
▪ Physical Inactivity
▪ Chlamydia Incidence
▪ Adult Smoking
▪ COVID-19 Cumulative Full Vaccination Rate
▪ Firearm Fatalities Rate
▪ Motor Vehicle Crash Death
▪ Disconnected Youth
▪ Third Grade Reading Level
▪ Third Grade Math Level</td></tr>
</table>

6. Health Equity: Equal Access to Opportunities to be Healthy

Health equity is defined as everyone having the same opportunity to be as healthy as possible.[8] Health is largely determined by social factors. Some communities have resources needed to be healthy readily available to them, while others do not. Many people experience barriers as the result of policies, practices, systems, and structures that discriminate against certain groups. Individual and community health can be improved by removing or mitigating practices that result in health inequity. While health equity is described as a specific health need in this assessment, it is recognized that equity plays a role in each health need in a community.

<table>
<tr><th colspan="2">Primary Data Analysis</th><th>Secondary Data Analysis</th></tr>
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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Healthcare services including mental health and specialty care are unaffordable to low-income populations.
▪ There is prejudice and limited cultural competence in the healthcare system.
▪ The pandemic has shined a light on structural inequities that lead to health disparities.
▪ Language barriers lead to health inequities.
▪ Structured racism is a public health crisis.
▪ Over-policing is an issue in some communities.
▪ Income and education inequity are pervasive in the community.
▪ There is little to no investment in communities of color.
▪ Hate crimes against the Asian American Pacific Islander (AAPI) community have continued to increase.
▪ Representation is important; the community needs individuals of color in healthcare provider and administration roles.</td><td>▪ This health need was not a previously identified health need and emerged during data analysis. Therefore, the Community Service Provider survey did not refer to this health need.</td><td>▪ This health need was not previously identified; therefore, no quantitative indicators were associated with this health need during data analysis.</td></tr>
</table>

[8] Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. *What is Health Equity?* (May 1, 2017). The Robert Wood Johnson Foundation. Retrieved: https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

7. Active Living and Healthy Eating

Physical activity and eating a healthy diet are important for one's overall health and well-being. Frequent physical activity is vital for prevention of disease and maintenance of a strong and healthy heart and mind. When access to healthy foods is challenging for community residents, many turn to unhealthy foods that are convenient, affordable, and readily available. Communities experiencing social vulnerability and poor health outcomes are often overloaded with fast food and other establishments where unhealthy food is sold. They are often challenged with food insecurity, lacking the means to consistently secure food for themselves or their families. When families rely on food pantries and school meals alone, these may not always provide sufficient nutrition for maintaining health.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Healthy foods are not as affordable as less healthy foods.
▪ Many parts of the community are not built to support a healthy lifestyle—no sidewalks or bike paths.
▪ Our communities are "car-centric," and result in less physical activity
▪ Food deserts are found throughout the Sacramento area.</td><td>▪ There are food deserts where fresh, unprocessed foods are not available.
▪ Food insecurity is an issue here.
▪ Students need healthier food options in school.
▪ The built environment doesn't support physical activity (e.g., neighborhoods aren't walkable, roads aren't bike friendly, or parks are inaccessible).
▪ The community needs nutrition education programs.
▪ Homelessness in parks or other public spaces deters their use.
▪ Grocery store options in the area are limited.</td><td>▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Diabetes Prevalence
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Colorectal Cancer Prevalence
▪ Breast Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Adult Obesity
▪ Physical Inactivity
▪ Limited Access to Healthy Foods
▪ Food Environment Index</td></tr>
</table>

8. Safe and Violence-Free Environment

Feeling safe in one's home and community is fundamental to overall health. Next to having basic needs met (e.g., food, shelter, and clothing) physical safety is essential. Feeling unsafe affects the way people act and react to everyday life occurrences. Furthermore, research has demonstrated that individuals exposed to violence in their homes, the community, and schools are more likely to experience depression and anxiety and demonstrate more aggressive, violent behavior.[9]

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ There are not enough safe places for youth to play outdoors.
▪ Some women stay in abusive marriages due to the stigma of being divorced.
▪ There is growing violence and gang activity in parts of the community.
▪ More investment needed in violence prevention, including teams that respond to gang violence.
▪ Lack of affordable housing forces many to move into unsafe environments.
▪ Hate crimes against the Asian American Pacific Islander (AAPI) community continue to rise; many go unreported due to fear of retaliation.
▪ Pedestrian safety continues to be an issue; the Stockton and Fruitridge intersection is known for being dangerous for pedestrians.</td><td>▪ People feel unsafe because of crime.
▪ There are not enough resources to address domestic violence and sexual assault.
▪ Human trafficking is an issue in the area.</td><td>▪ Life Expectancy
▪ Premature Death
▪ Hypertension Mortality
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Physical Inactivity
▪ Homicide Rate
▪ Firearm Fatalities Rate
▪ Violent Crime Rate
▪ Motor Vehicle Crash Death
▪ Disconnected Youth</td></tr>
</table>

[9] Lynn-Whaley, J., & Sugarmann, J. July 2017. *The Relationship Between Community Violence and Trauma*. Los Angeles: Violence Policy Center.

9. Increased Community Connections

As humans are social beings, community connection is a crucial part of living a healthy life. People have a need to feel connected with a larger support network and the comfort of knowing they are accepted and loved. Research suggests "individuals who feel a sense of security, belonging, and trust in their community have better health. People who don't feel connected are less inclined to act in healthy ways or work with others to promote well-being for all."[10] Assuring that community members have ways to connect with each other through programs, services, and opportunities is important in fostering a healthy community. Furthermore, healthcare and community support services are more effective when they are delivered in a coordinated fashion, where individual organizations collaborate with others to build a network of care.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Community engagement is needed to rebuild trust between communities and the medical and scientific community.
▪ Healthcare, mental health, and social services are siloed; these need more integration.
▪ The community needs more grassroots efforts to build support for disenfranchised groups.
▪ The community needs to embed social workers in the police department.
▪ Substance-use organizations need to be more integrated in local emergency departments.
▪ Isolation has increased during the pandemic, especially for certain groups, e.g., seniors.
▪ The loss of trust in government and sense of fragmentation among communities has grown during the pandemic.
▪ "People heal better when they can come together."
▪ Federally Qualified Health Centers (FQHCs) can be hubs to link patients to other services, but often fall short.</td><td>▪ Health and social service providers operate in silos; cross-sector connections are needed.
▪ Building community connections doesn't seem like a focus in the area.
▪ Relations between law enforcement and the community need to improve.
▪ City and County leaders need to work together.</td><td>▪ Infant Mortality
▪ Child Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Suicide Mortality
▪ Unintentional Injuries Mortality
▪ Diabetes Prevalence
▪ Low Birthweight
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days</td><td>▪ Frequent Physical Distress
▪ Poor or Fair Health Excessive Drinking
▪ Drug-Induced Death
▪ Physical Inactivity
▪ Primary Care Shortage Area
▪ Mental Health Care Shortage Area
▪ Medically Underserved Area
▪ Preventable Hospitalization
▪ COVID-19 Cumulative Full Vaccination Rate
▪ Homicide Rate
▪ Firearm Fatalities Rate
▪ Violent Crime Rate
▪ Disconnected Youth
▪ Children in Single-Parent Households</td></tr>
</table>

[10] Robert Wood Johnson Foundation. 2016. *Building a Culture of Health: Sense of Community.* See: https://www.rwjf.org/en/cultureofhealth/taking-action/making-health-a-shared-value/sense-of-community.html

10. Access to Specialty and Extended Care

Extended care services, which include specialty care, are services provided in a particular branch of medicine and focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists such as endocrinologists, cardiologists, and gastroenterologists, community residents are often left to manage the progression of chronic diseases, including diabetes and high blood pressure, on their own. In addition to specialty care, extended care refers to care extending beyond primary care services to support overall physical health and wellness, such as skilled-nursing facilities, hospice care, and in-home healthcare.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ More dialysis services are needed in the community; existing services cannot keep up with demand.
▪ There are excessive wait-times for appointments to see specialists.
▪ The community needs more specialists willing to serve low-income residents.
▪ Specialty services are unaffordable to the low-income community.
▪ Long-term care is expensive and unavailable for many low-wage earners.
▪ Many have to travel outside of the community to see specialists.
▪ Medi-Cal insurance plans have a narrow set of services available, with high out-of-pocket costs.
▪ For those without insurance that need specialty care, it can take months to get enrolled in Medi-Cal.
▪ Hospice care is needed for the homeless community.</td><td>▪ Wait times for specialists' appointments are excessively long.
▪ The area needs more extended care options for the aging population (e.g., skilled nursing homes, in-home care).
▪ People have to travel to reach specialists.
▪ Too few specialty and extended care providers accept Medi-Cal.</td><td>▪ Infant Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Stroke Mortality
▪ Chronic Lower Respiratory Disease Mortality
▪ Diabetes Mortality
▪ Heart Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Alzheimer's Disease Mortality
▪ Diabetes Prevalence
▪ Poor Mental Health Days
▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Lung Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Drug-Induced Death
▪ Preventable Hospitalization</td></tr>
</table>

11. Access to Functional Needs–Transportation and Physical Disability

Functional needs include indicators related to transportation and disability. Having access to transportation services to support individual mobility is a necessity of daily life. Without transportation, individuals struggle to meet their basic needs, including those needs that promote and support a healthy life. The number of people with a disability is also an important indicator for community health and must be examined to ensure that all community members have access to necessities for a high quality of life.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Access to transportation to receive medical services is a challenge for many.
▪ Public transportation is a challenge as it does not serve many parts of the community.
▪ Public transportation shuts down in the evenings leaving many without transportation after business hours.
▪ There are limited transportation options for lower-income populations that cannot afford a car.
▪ There are limited public transportation options for those living with disabilities.</td><td>▪ There were no responses by those who participated in the survey to the question of how this health need expressed itself in the Sacramento County community.</td><td>▪ Disability
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Adult Obesity
▪ COVID-19 Cumulative Full Vaccination Rate</td></tr>
</table>

12. Access to Dental Care and Preventive Services

Oral health is important for overall quality of life. When individuals have dental pain, it is difficult to eat, concentrate, and fully engage in life. Oral health disease, including gum disease and tooth decay are preventable chronic diseases that contribute to increased risk for other chronic diseases, as well as play a large role in chronic school absenteeism in children. Poor oral health status impacts the health of the entire body, especially the heart and the digestive and endocrine systems.

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<tr><td>Key Informant and Focus Group Data</td><td>Community Service Provider Survey Data</td></tr>
<tr><td>▪ Dental providers offer minimal services to Medi-Cal enrollees.
▪ Many Medi-Cal enrollees are treated in emergency departments for dental issues because they cannot access a dentist.
▪ There are excessive wait times for children to see a dentist.</td><td>▪ There aren’t enough providers in the area that accept Medi-Cal.
▪ Dental care is unaffordable, even if you have insurance.
▪ There aren’t enough dental providers in the area.
▪ The lack of access to dental care leads to overuse of emergency departments.
▪ Quality dental services for kids are limited.</td><td>▪ Frequent Mental Distress
▪ Poor Physical Health Days
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Dentists per 100K of population</td></tr>
</table>

13. Healthy Physical Environment

Living in a pollution-free environment is essential for health. Individual health is determined by a number of factors, and some models show that one's living environment, including the physical (natural and built) and sociocultural environment, has more impact on individual health than other factors such as one's lifestyle, heredity, or access to medical services.[11]

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<tr><td>▪ Illegal dumping is an issue in parts of the community.
▪ Landlords that do not maintain properties should be held legally accountable.</td><td>▪ Low-income housing is substandard.
▪ The air quality contributes to high rates of asthma.
▪ Wildfires in the region harm the air quality.</td><td>▪ Infant Mortality
▪ Life Expectancy
▪ Premature Age-Adjusted Mortality
▪ Premature Death
▪ Chronic Lower Respiratory Disease Mortality
▪ Hypertension Mortality
▪ Cancer Mortality
▪ Frequent Mental Distress
▪ Frequent Physical Distress
▪ Poor or Fair Health
▪ Colorectal Cancer Prevalence
▪ Breast Cancer Prevalence
▪ Lung Cancer Prevalence
▪ Asthma ED Rates
▪ Asthma ED Rates for Children
▪ Adult Smoking
▪ Air Pollution - Particulate Matter
▪ Drinking Water Violations</td></tr>
</table>

[11] See Blum, H. L. 1983. *Planning for Health*. New York: Human Sciences Press

Description of Community Served—Sacramento County

Sacramento County was the designated area served by the participating hospitals for the 2022 CHNA. This definition of the community served was used because this is the primary geographic area served by the seven nonprofit hospitals that collaborated on this CHNA.

Sacramento County was incorporated in 1850, and much of its rich history was influenced by the discovery of gold in the area in 1848. The county is home to California's capital city, Sacramento. The county includes seven incorporated cities, with the City of Sacramento being the largest. Covering a geographic area of 994 square miles and home to approximately 1.56 million residents, Sacramento County sits at the northern portion of California's Central Valley, situated along the Interstate 5 corridor. The area consists of both urban and rural communities and includes the Sacramento–San Joaquin Delta that connects the Sacramento River to the San Francisco Bay through some 700 miles of winding waterways. Sacramento is a diverse community, and a report ranked the city the fourth most racially and ethnically diverse large city in the US.[12]

Sacramento County has over 30 cities, census-designated places, and unincorporated communities that include neighborhoods with rich heritages such as Oak Park, known as Sacramento's first suburb, to newer communities such as the City of Rancho Cordova, incorporated in 2003. Sacramento County ranks as California's 26th most overall healthy county among the 58 in the state.[13] The area is served by a number of healthcare organizations, including those that collaborated on this assessment.

In this CHNA, two additional ZIP Codes from El Dorado County, a neighboring county east of Sacramento, were included to capture the portion of the community served by Mercy Hospital of Folsom, located near the border of these two counties. With some exceptions, findings described in this report are organized both at the county level and, as detailed later in this report, by designated regions within the county.

Regions of Sacramento County

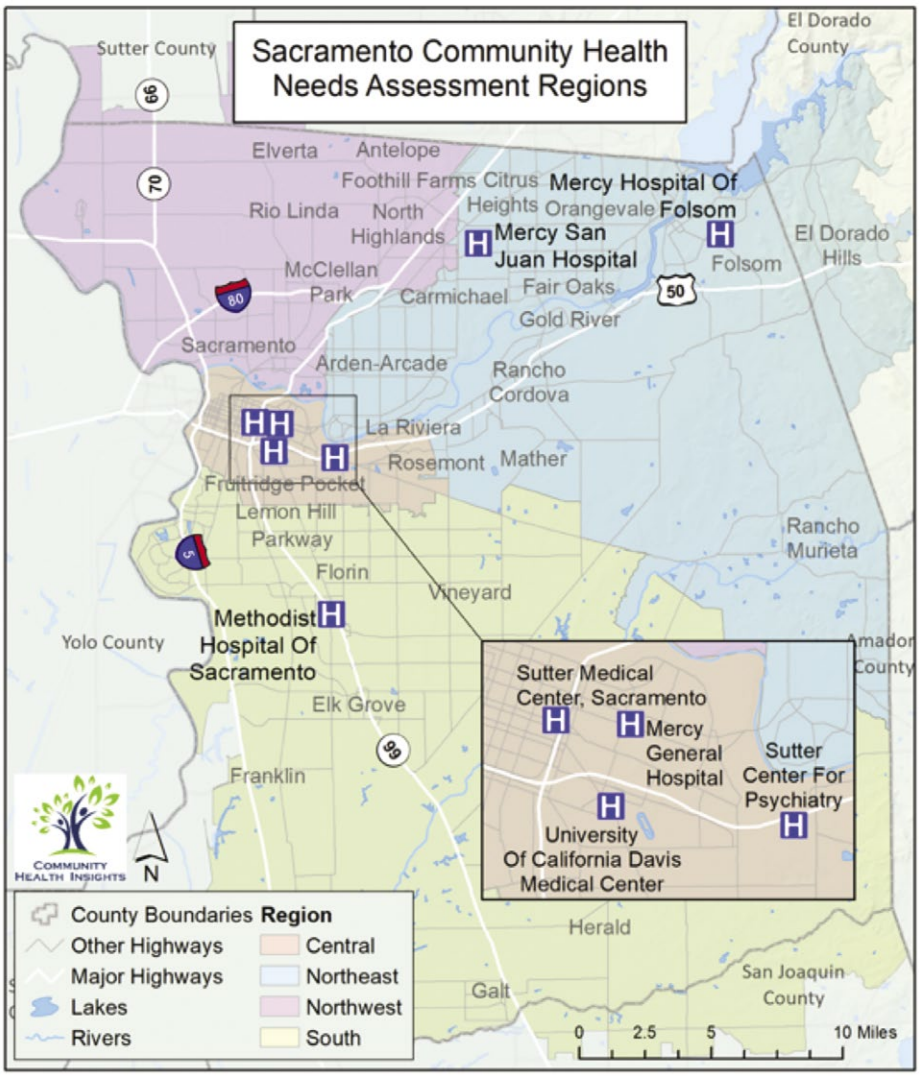
Sacramento County has a population of over 1.5 million residents and is comprised of many communities, each with unique attributes and characteristics that influence community health. In an effort to capture these unique attributes for this CHNA, the county was subdivided into four distinct regions to allow for more detailed data collection and analysis. These regions are shown in Figure 2. Primary data collection included interviews with community health experts and community residents that lived and worked in the communities within these regions, thus providing a richer and more robust understanding of each community's unique features. When available, secondary data were collected and analyzed within each region as well.

The following sections give more detailed information and findings that are unique to each region. To begin, a description of each community is presented, followed by sociodemographic information for each ZIP Code in the region. These are followed by displays of two informative findings of the CHNA: 1) the California Healthy Places Index, and 2) Communities of Concern within each region.

[12] McCann, A. (May 3, 2018). *2018's Most Diverse Cities in the U.S.* Washington DC: WalletHub. (Retrieved: https://wallethub.com/edu/most-diverse-cities/12690/#methodology).

[13] See: https://www.countyhealthrankings.org/app/california/2021/rankings/outcomes/overall

Figure 2: Map of Sacramento County regions



California Healthy Places Index

The California Healthy Places Index (HPI) is an index based on 25 health-related measures for communities across California.[14] Measures included in the HPI were selected based on their known relationship to life expectancy and other health outcomes. These values are combined into a final score representing the overall health and well-being of the community, which can then be used to compare the factors influencing health between communities. Higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present.

[14] Public Health Alliance of Southern California. 2021. The California Health Places Index (HPI): About. Retrieved 26 July 2021 from https://healthyplacesindex.org/about/.

Communities of Concern

Communities of Concern are geographic areas in Sacramento County that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health. Communities of Concern are important to the overall CHNA methodology because, after the service area has been assessed more broadly, they allow for a focus on those portions of the region likely experiencing the greatest health disparities. Geographic Communities of Concern were identified using a combination of primary and secondary data sources. (Refer to the technical section of this report for an in-depth description of how these are identified). For this assessment, a total of 50 ZIP Codes were included across all of Sacramento County; of these, 19 met the requirements to be included as a Community of Concern. The total population within these communities was approximately 700,000 residents, representing 44% of the total population in the service area.

Findings for Each Region

Prioritized Significant Health Needs by Region

While a goal of the assessment was to identify the health needs of Sacramento County as a whole, it was also important to identify and prioritize health needs for the multiple communities within the county. To accomplish this, data were collected and analyzed at two levels. Health need identification and prioritization for the county overall was based on all qualitative data collected across the county. However, health need identification and prioritization for each region was based on qualitative data collected only within that particular region. This resulted in differences between the health needs identified and prioritized for the entire county and those identified and prioritized for each region.

After each region's health needs were identified, they were prioritized based on an analysis of primary data sources that mentioned the health need as a priority. The findings are displayed in Table 2.

Table 2: Ranking of prioritized significant health needs for each region and Sacramento County

Significant Health Need	Northeast	Northwest	Central	South	*County*
Access to Mental/Behavioral/Substance-use Services	1	1	2	2	*1*
Access to Basic Needs Such as Housing, Jobs, and Food	2	2	1	1	*2*
Access to Quality Primary Care Health Services	3	3	3	3	*3*
System Navigation	4	7	4	4	*4*
Injury and Disease Prevention and Management	5	5	6	7	*5*
Health Equity: Equal Access to Opportunities to be Healthy	7	9	5	5	*6*
Active Living and Healthy Eating	9	6	11	9	*7*
Safe and Violence-Free Environment	11	11	7	6	*8*
Increased Community Connections	6	4	8	8	*9*
Access to Specialty and Extended Care	10	10	10	10	*10*
Access to Functional Needs	8	8	9	11	*11*
Access to Dental Care and Preventive Services	13	12	12	13	*12*
Healthy Physical Environment	12	13	13	12	*13*

Northeast Region

The Northeast Region is comprised of 15 ZIP Codes and is home to 540,637 residents. Table 3 displays population characteristics for each ZIP Code. Data are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 3: Population characteristics for each ZIP Code located in Northeast Region

Zip Code	Total Population	% Non-White or Hispanic/Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95608	62,539	30.8	41.7	$64,059	14.7	6.5	6.0	6.7	38.7	15.4
95610	46,305	31.8	36.5	$61,461	12.1	6.2	6.8	10.0	41.6	15.9
95621	41,740	29.0	39.7	$63,214	10.8	6.2	4.7	9.3	36.5	15.5
95628	40,855	25.7	45.4	$86,181	8.4	4.7	4.7	5.5	31.6	11.1
95630	78,159	38.2	40.7	$114,405	5.6	3.1	2.5	6.2	28.2	7.6
95655	4,156	44.8	36.4	$86,486	13.5	8.6	2.7	6.7	33.9	7.5
95662	32,172	23.6	41.2	$80,434	7.9	5.4	5.2	6.6	34.9	13.7
95670	55,558	46.8	36.7	$67,015	13.1	7.3	6.3	10.0	37.2	13.7
95683	6,326	24.2	50.1	$108,338	4.5	3.5	0.6	3.1	25.5	12.7
95742	12,472	55.7	34.5	$132,636	6.2	6.4	3.5	3.6	25.8	9.1
95762	43,052	25.7	44.4	$142,453	3.2	4.4	1.7	3.7	30.0	7.6
95821	35,812	45.4	37.4	$42,456	24.3	8.9	5.7	10.5	48.7	12.1
95825	37,473	54.4	32.1	$40,515	31.4	10.7	8.2	13.8	51.6	11.4
95827	20,666	57.1	35.2	$59,115	12.6	7.7	5.9	13.7	39.0	15.5
95864	23,352	29.2	46.4	$105,849	7.4	4.4	3.1	3.9	27.6	12.0
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau

Healthy Places Index–Northeast Region

Figure 3 displays the HPI for the Northeast Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated "less healthy" and are shaded in blue.

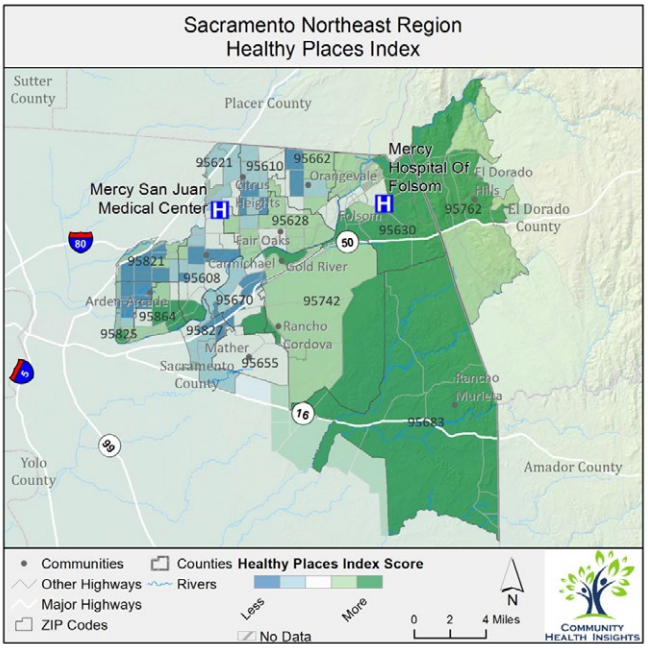


Figure 3: Healthy Places Index for Northeast Region

Northeast Region Communities of Concern

Six ZIP Codes in the Northeast Region met the criteria to be classified as Communities of Concern. These are shown in Figure 4 and described in Table 4 with the census population provided for each.

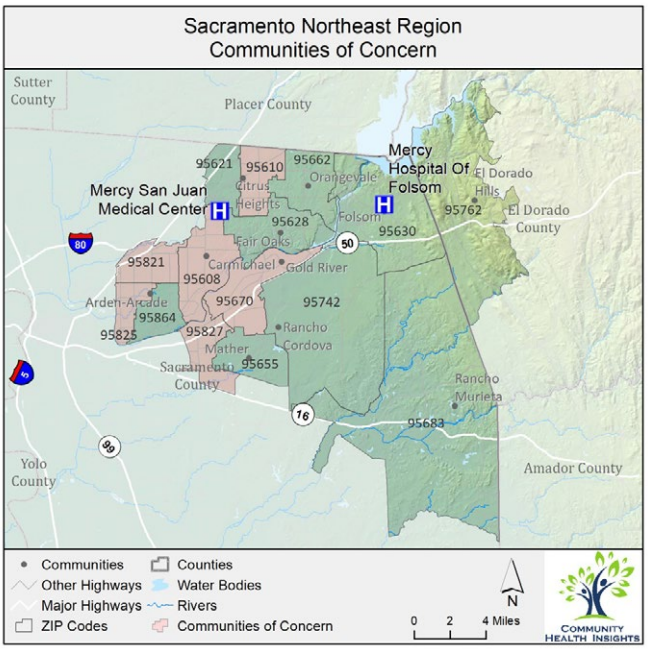


Figure 4: Communities of Concern for Northeast Region

Table 4: Identified Communities of Concern for the Northeast Region

Zip Code	Community/Area	Population
95608	Carmichael	62,539
95610	Citrus Heights	46,305
95670	Rancho Cordova	55,558
95821	Arden Arcade, North Highlands	35,812
95825	Arden Arcade, North Highlands	37,473
95827	Rancho Cordova, Rosemont	20,666
Total Population in Communities of Concern		*258,353*
Total Population in Northeast Region		*540,637*
Percentage of Northeast Region Population in Communities of Concern		*47.8%*

Northwest Region

The Northwest Region is comprised of 13 ZIP Codes. The area is home to 336,702 residents. Table 5 displays population characteristics for each ZIP Code. Data are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 5: Population characteristics for each ZIP Code located in the Northwest Region

Zip Code	Total Population	% Non-White or Hispanic/Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95626	6,065	28.2	41.4	$75,481	11.4	4.4	7.5	12.2	35.9	10.1
95652	789	51.3	30.7	$33,000	61.3	10.7	2.9	15.1	62.8	27.0
95660	35,461	54.4	31.1	$45,845	25.1	4.6	7.2	18.2	44.6	11.6
95673	16,636	35.2	36.8	$70,876	15.2	5.0	6.0	13.4	33.6	12.9
95815	25,673	70.7	32.3	$34,583	29.8	11.9	10.3	24.2	54.5	12.4
95833	39,905	71.9	31.5	$63,418	11.7	6.1	5.8	12.3	37.4	9.1
95834	30,076	75.7	32.2	$64,996	15.6	6.6	4.1	11.8	42.1	8.7
95835	40,170	65.7	38.2	$102,895	4.7	3.5	4.9	7.4	32.0	6.9
95837	300	16.3	47.3	$219,063	11.0	9.0	7.3	5.0	17.7	11.0
95838	39,053	78.4	31.0	$48,416	22.7	6.9	7.5	25.7	49.5	11.1
95841	21,229	44.4	34.5	$50,295	19.1	4.1	7.7	8.2	43.7	11.2
95842	33,522	48.6	32.9	$53,458	19.7	8.3	7.2	13.3	45.8	12.9
95843	47,823	41.3	32.9	$81,028	11.2	3.5	5.8	7.2	35.8	8.5
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau

California Healthy Places Index–Northwest Region

Figure 5 displays the HPI for the Northeast Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

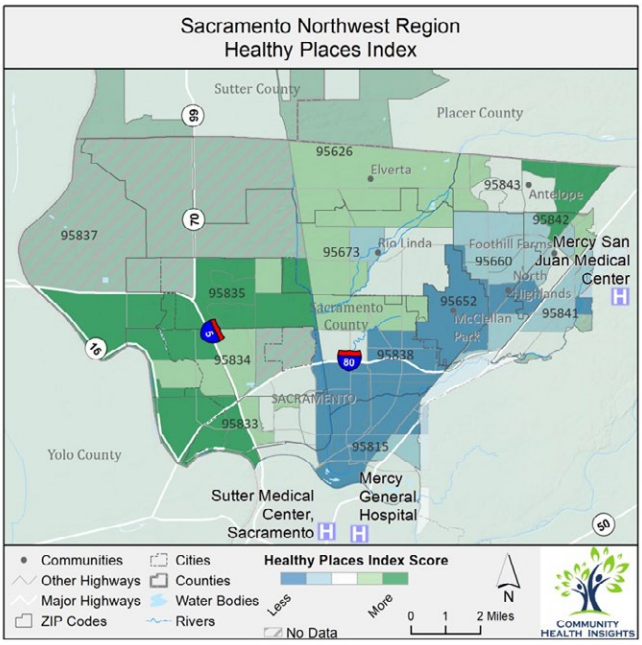


Figure 5: Healthy Place Index for Northwest Region

Communities of Concern–Northwest Region

Five ZIP Codes in the Northwest Region met the criteria to be classified as Communities of Concern. These are shown in Figure 6 and described in Table 6 with the census population provided for each.

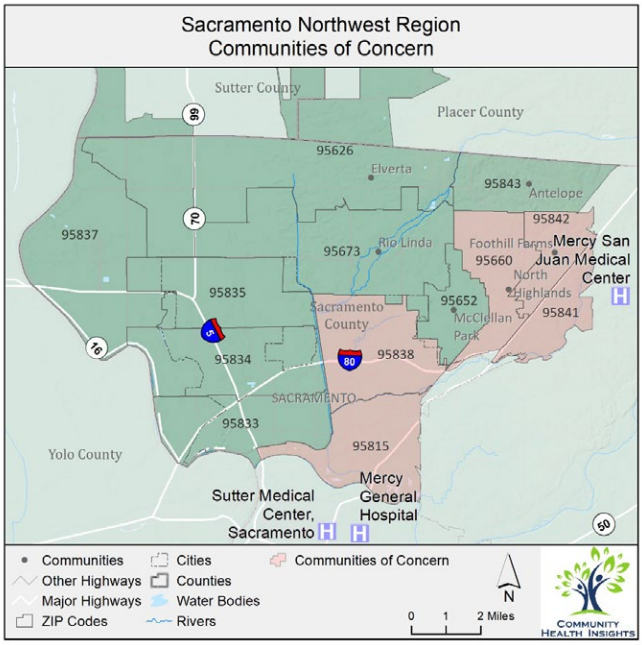


Figure 6: Communities of Concern for Northwest Region

Table 6: Identified Communities of Concern for the Northwest Region

Zip Code	Community/Area	Population
95660	North Highlands	35,461
95815	North Sacramento	25,673
95838	Del Paso Heights	39,053
95841	Arden Arcade, North Highlands	21,229
95842	Arden Arcade, North Highlands, Foothill Farms	33,522
	Total Population in Communities of Concern	*154,938*
	Total Population in Northwest Region	*336,702*
	Percentage of Northwest Region Population in Communities of Concern	*46.0%*

Central Region

The Central Region is comprised of eight ZIP Codes. The area is home to 166,256 residents. Table 7 displays population characteristics for each ZIP Code. Data provided are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to either the county or state benchmark are highlighted.

Table 7: Population characteristics for each ZIP Code located in the Central Region

Zip Code	Total Population	% Non-White or Hispanic/Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95811	6,294	48.2	32.0	$59,254	26.2	5.2	4.9	9.4	35.4	13.9
95814	11,908	49.7	34.0	$33,938	27.8	6.8	4.8	13.4	47.5	18.5
95816	17,199	31.5	34.6	$72,270	9.7	4.2	5.6	4.7	29.9	11.9
95817	13,758	54.0	35.5	$50,925	21.9	6.3	7.1	15.7	37.8	14.0
95818	21,625	44.2	39.2	$84,908	15.0	6.2	2.6	6.1	27.5	10.6
95819	19,890	30.5	36.4	$106,514	6.8	4.2	2.1	1.6	23.5	7.6
95820	36,437	67.5	35.1	$51,068	21.6	9.9	9.5	20.2	41.3	14.5
95826	39,145	52.2	33.5	$64,241	17.7	6.3	5.0	8.1	36.4	13.3
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau

California Healthy Places Index–Central Region

Figure 7 displays the HPI for the Central Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated "less healthy" and are shaded in blue.

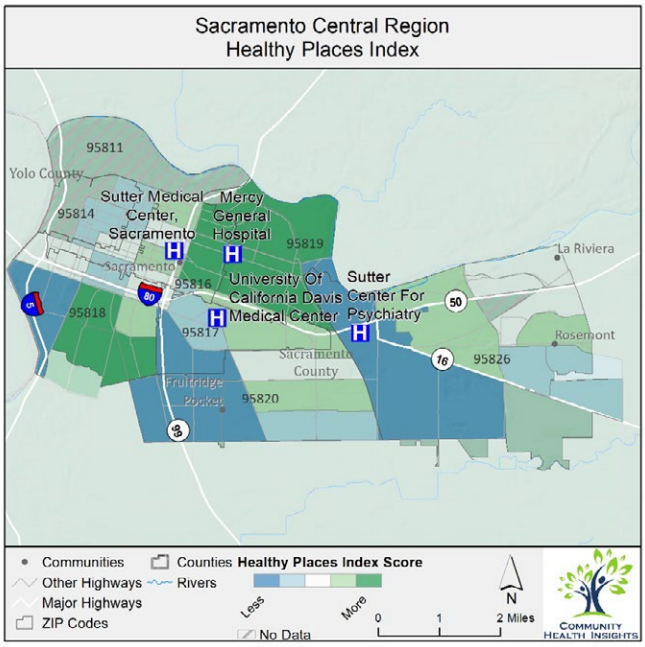


Figure 7: Healthy Places Index for Central Region

Communities of Concern–Central Region

Four ZIP Codes in the Central Region met the criteria to be classified as Communities of Concern. These are shown in Figure 8 and described in Table 8 with the census population provided for each.

Figure 8: Communities of Concern for Central Region

Table 8: Identified Communities of Concern for the Central Region

Zip Code	Community/Area	Population
95811	Downtown Sacramento	6,294
95814	Downtown Sacramento	11,908
95817	Oak Park	13,758
95820	Oak Park, Tahoe Park	36,437
	Total Population in Communities of Concern	*68,397*
	Total Population in Central Region	*166,256*
	Percentage of Central Region Population in Community of Concern	*41.14%*

Southern Region

The Southern Region is comprised of 14 ZIP Codes and is home to 520,960 residents. Table 9 displays population characteristics for each ZIP Code. Data provided are compared to the state and county rates, and ZIP Codes that negatively varied or performed poorly when compared to the either the state or county benchmark are highlighted.

Table 9: Population characteristics for each ZIP Code located in the Southern Region

Zip Code	Total Population	% Non-White or Hispanic/Latinx	Median Age (yrs.)	Median Income	% Poverty	% Unemployment	% Uninsured	% Without High School Graduation	% With High Housing Costs	% With Disability
95624	65,948	60.0	37.9	$93,090	8.4	6.1	2.9	10.3	34.3	11.2
95632	31,911	52.9	36.5	$76,334	9.5	6.0	6.5	18.1	30.9	11.6
95638	2,126	30.6	49.6	$92,708	8.2	3.4	3.9	9.1	25.1	13.2
95693	7,037	36.5	47.7	$100,265	7.9	4.6	1.6	9.4	26.4	9.3
95757	50,727	72.3	36.1	$105,390	7.7	3.8	2.0	9.7	34.6	8.9
95758	65,811	68.2	37.4	$85,221	9.4	6.6	3.2	10.3	32.5	9.7
95822	44,741	74.1	38.1	$57,535	15.8	8.3	6.0	17.0	37.3	14.4
95823	79,440	84.8	31.4	$47,553	22.2	10.0	7.7	22.7	48.1	12.4
95824	30,296	85.7	32.7	$38,985	30.8	9.6	9.7	37.7	47.8	14.4
95828	58,717	81.4	36.4	$53,229	20.6	11.1	6.9	24.1	42.9	13.8
95829	28,264	67.7	35.5	$93,377	9.2	4.7	4.2	11.1	32.3	9.4
95830	734	36.1	54.6	$101,786	9.5	2.1	0.4	5.5	27.5	30.0
95831	43,094	63.9	43.8	$79,368	7.4	4.6	3.4	6.7	32.0	11.7
95832	12,114	91.3	29.7	$47,341	22.1	12.7	5.1	26.2	48.7	14.6
Sacramento	*1,524,553*	*55.3*	*36.2*	*$67,151*	*14.7*	*6.5*	*5.5*	*12.3*	*37.9*	*11.8*
California	*39,283,497*	*62.8*	*36.5*	*$75,235*	*13.4*	*6.1*	*7.5*	*16.7*	*40.6*	*10.6*

Source: 2019 American Community Survey 5-year estimates; U.S. Census Bureau

California Healthy Places Index–Southern Region

Figure 9 displays the HPI for the Southern Region. As described earlier, higher HPI index values are found in communities with a collection of factors that contribute to greater health, and lower HPI values are found in communities where these factors are less present. In the map, those communities with lower values are designated “less healthy” and are shaded in blue.

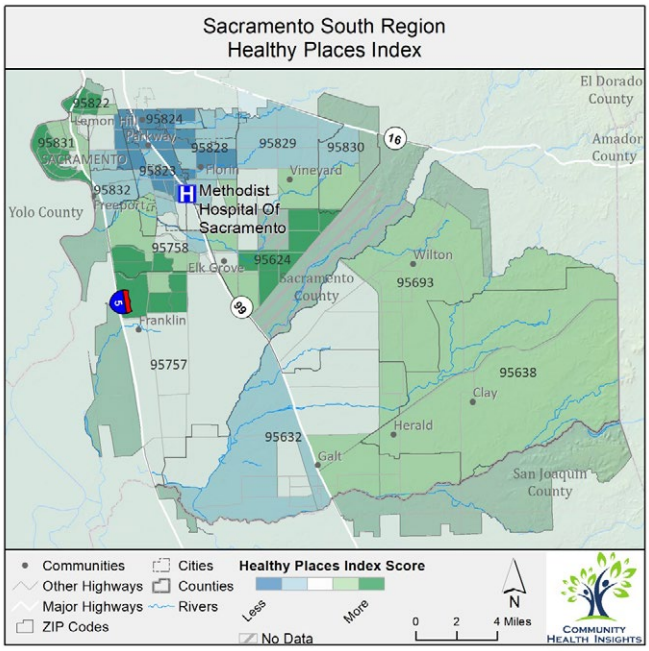


Figure 9: Healthy Place Index for the Southern Region

Communities of Concern–Southern Region

Five ZIP Codes in the Southern Region met the criteria to be classified as Communities of Concern. These are shown in Figure 10 and described in Table 10 with the census population provided for each.

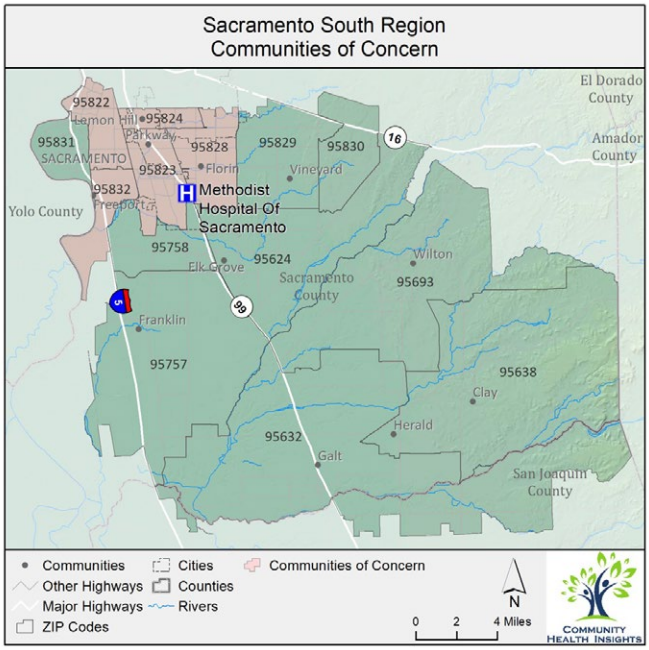


Figure 10: Communities of Concern for the Southern Region

Table 10: Identified Communities of Concern for the Southern Region

Zip Code	Community/Area	Population
95822	South Sacramento	44,741
95823	South Sacramento	79,440
95824	South Sacramento	30,296
95828	South Oak Park, South Sacramento	58,717
95832	Meadowview, Freeport	12,114
Total Population in Communities of Concern		*225,308*
Total Population in Southern Region		*520,960*
Percentage of Southern Region Population in Communities of Concern		*43.3%*

Health Equity

The following section is a high-level summary of health equity in Sacramento County and is not intended to provide an extensive exploration of inequity in the service area. Quantifying and describing inequity in a community is challenging due to data limitations and the fact that inequity is a contributor to all health needs that exist in a community. The manner in which inequity manifests across Sacramento County is described in greater detail earlier in this report.

The Robert Wood Johnson Foundation's definition of health equity and social justice is used here to help establish a common understanding for the concept of health equity:

"Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

Inequities experienced early and throughout one's life, such as limited access to a quality education, have health consequences that appear later in life as health disparities. Health disparities are defined as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health experienced by populations, and defined by factors such as race or ethnicity, gender, education or income, disability, geographic location or sexual orientation."[15]

In the U.S. and many parts of the world, inequities are most apparent when comparing various racial and ethnic groups to one another. These comparisons clearly demonstrate that health inequities persist across communities, including Sacramento County.

This section of the report follows the organizing framework used throughout this assessment—the Robert Wood Johnson Foundation's County Health Rankings model.[16] The model shows that health outcomes are the result of health factors one experiences throughout life. Understanding where inequities appear helps in the planning of targeted interventions to reduce the ill-effects of inequity.

[15] Center for Disease Control and Prevention. 2008. Health Disparities Among Racial/Ethnic Populations. Community Health and Program Services (CHAPS): Atlanta: U.S. Department of Health and Human Services.
[16] See: County Health Rankings Model, Robert Wood Johnson Foundation, and University of Wisconsin, 2021. Retrieved from: http://www.countyhealthrankings.org/.

Health Outcomes—the Results of Inequity

Table 11 displays disparities among race and ethnic groups for the service area for life expectancy, mortality, and low birth weight.

When examining health outcomes across all race and ethnic groups disparities are apparent. For example, the infant mortality rate for Blacks is over twice the rate for Whites.

Table 11: Health outcomes comparing race and ethnicity in the service area

Health Outcomes	Description	American Indian/Alaska Native	Asian	Black	Hispanic	White	Overall
Infant Mortality	Number of all infant deaths (within 1 year), per 1,000 live births	~	4.6	8.6	4.7	3.8	4.9
Life Expectancy	Average number of years a person can expect to live	74.8	34.0	75.1	82.8	78.9	79.6
Child Mortality	Number of deaths among children un-der age 18 per 100,000 population	~	34.6	62.3	39.8	37.9	41.5
Premature Age-Adjusted Mortality	Number of deaths among residents under age 75 per 100,000 population (age-adjusted)	479	35.5	523.2	258.5	338.7	325
Premature Death	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	10,827	39.2	10,712	5,352	6,430	6,381
Low Birthweight	Percentage of live births with low birthweight (< 2,500 grams)	7.9%	36.4	11%	6.4%	5.4%	6.9%

~ Data Not Available; unless otherwise noted, data sources included in the technical section of the report.

Health Factors—Inequities in the Service Area

Inequities can be seen in data that help describe health factors in the service area, such as education attainment and income. These health factors are displayed in Table 12 and are compared across race and ethnic groups. The indicators used in this table were selected based their ability to describe inequity across race and ethnic groups across Sacramento County. The inclusion of these particular equity-oriented indicators was guided by a review of previous research.[17]

When comparing health factor data across race and ethnic groups inequities are apparent. For example, median household income is notably lower for Black and Hispanic groups compared to all others. Furthermore, the percent of Hispanics that were uninsured was significantly higher than most other groups.

Table 12: Health factors comparing race and ethnicity in the service area

Health Factors	Description	American Indian/Alaska Native	Asian	Black	Hispanic	White	Overall
Some College[a]	Percentage of adults ages 25 and over with some post-secondary education	55.7%	65%	65.3%	46.7%	72.6%	65.3%
High School Completion	Percentage of adults ages 25 and over with at least a high school diploma or equivalent	81.5%	82.2%	90.1%	74%	94.2%	87.7%
Third Grade Reading Level	Average grade level performance for 3rd graders on English Language Arts standardized tests	~	3.1	2.3	2.6	3.1	2.8
Third Grade Math Level	Average grade level performance for 3rd graders on math standardized tests	~	3	2.1	2.4	2.9	2.7
Children in Poverty	Percentage of people under age 18 in poverty	32.3%	18.7%	28.9%	23.7%	13.5%	16%
Median Household Income	The income where half of households in a county earn more and half of households earn less	$54,080	$74,804	$48,321	$57,031	$75,110	$71,891
Uninsured Population[b]	Percentage of the civilian non-institutionalized population without health insurance	7.5%	4.7%	4.2%	9.4%	4%	5.5%

~ Data Not Available; unless otherwise noted, data sources included in the technical section of the report
[a] From 2019 American Community Survey 5-year estimates tables B15002, C15002B, C15002C, C15002D, C15002H, and C15002I.
[b] From 2019 American Community Survey 5-year estimates table S2701.

[17] For example, see: Stillman, L. & Ridini, S. (May 2015). *Embracing Equity in Community Health Improvement*. Health Resources in Action Policy and Practice Report. Accessed: https://hria.org/wp-content/uploads/2016/02/Embracing-Equity-in-Community-Health-Improvement.pdf.

Population Groups Experiencing Disparities

The following section describes populations in the service area identified through qualitative data analysis as experiencing health disparities. Interview participants were asked, “What specific groups of community members experience health issues the most?” Responses were analyzed by counting the total number of times all key informants and focus-group participants mentioned a particular group as one experiencing disparities. Figure 11 displays the results of this analysis. The groups are not mutually exclusive—one group may be a subset of another group. One of the purposes of identifying the sub-populations was to help guide additional qualitative data collection efforts to focus on the needs of these population groups.

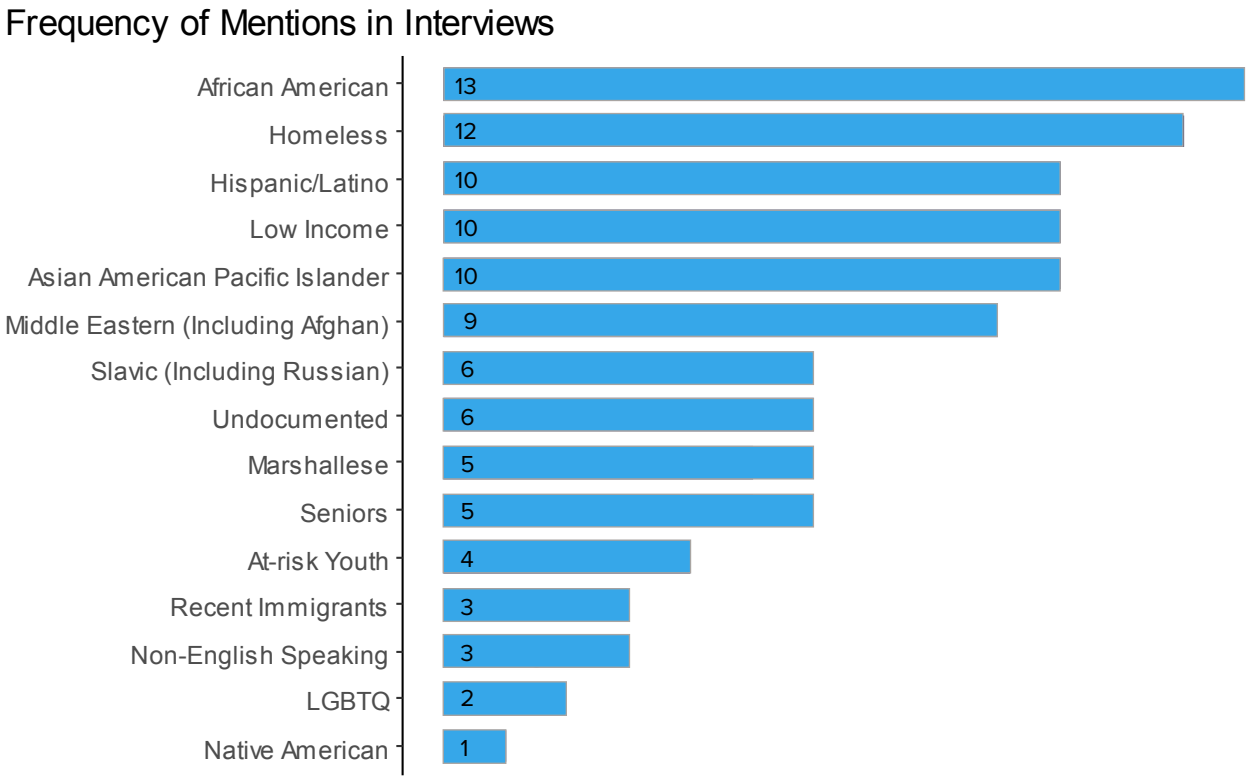


Figure 11: Populations experiencing disparities in the service area

The Impact of COVID on Health Needs

COVID-related health indicators for the service area are noted in Table 13.

Table 13: COVID-19-related rates for the service area

Indicators	Description	Rates	
COVID-19 Mortality	Number of deaths due to COVID-19 per 100,000 population.	Sacramento California	150.8 185.1
COVID-19 Case Fatality	Percentage of COVID-19 deaths per laboratory-confirmed COVID-19 cases.	Sacramento California	1.4% 1.5%
COVID-19 Cumulative Incidence	Number of laboratory-confirmed COVID-19 cases per 100,000 population.	Sacramento California	10,567.2 12,087.6
COVID-19 Cumulative Full Vaccination Rate	Number of completed COVID-19 vaccinations per 100,000 population.	Sacramento California	60,513.9 63,134.6

Data in Table 13 collected as of 11/17/21. Data sources included in the technical section of the report.

Table 14 displays COVID-19 cases and testing percentages by race and ethnicity for Sacramento County.

Table 14: Cases/testing percentages and cases per 100K of population by race/ethnicity in Sacramento County

	% County Population	% Cases in Sacramento County	% Testing in Sacramento County	Cases per 100K of population
Black	10.6	13.3	11.9	1,751
Hispanic/Latino	22.9	25.6	21.6	1,558
Asian American	16.2	17.6	17.4	1,514
White	46.1	39.7	46.7	1,202
Multi-Race	2.6	1.1	0.6	620
American Indian or Alaskan Native	0.6	~	~	~
Native Hawaiian/ other Pacific Islander	1.0	~	~	~

~ Data not shown because there were fewer than 20,000 people in this group.

Source: COVID19.CA.GOV. Retrieved January 12, 2022.

Key informants and focus group participants, as well as respondents to the Community Service Provider survey, were asked how the COVID-19 pandemic had impacted health needs. A summary of their responses is described in Table 15.

Table 15: The impacts of COVID-19 on health need as identified in primary data sources

Primary Data Analysis	
Key Informant and Focus Group Data	**Community Service Provider Survey Data**
▪ The pandemic exacerbated existing challenges faced by many in the community. ▪ There has been a marked increase in demand for mental, behavioral, and substance-use services due to the stress of the pandemic; especially in youth and seniors. ▪ Violence, both in the home and community, has increased. ▪ There has been a marked increase in violence and hate crimes against the AAPI community. ▪ There has been an increase in evictions leading to homelessness during the pandemic. ▪ Community members have been avoiding preventative care (e.g., immunizations, wellness visits, screenings) and chronic disease management (e.g., medications) due to fear of exposure to COVID. ▪ Children not being in school led to a host of issues, such as the struggles of distance learning and the loss of services offered by schools. ▪ Youth experienced a rise in domestic violence due to being home more; schools, which often detect this violence, were unable to intervene or report it. ▪ The "digital divide" further exposed the challenges many face in distance learning and the shift to telehealth. ▪ The trust between communities and government has been eroded. ▪ COVID spread through essential workers that were unable to stay home; many live in multi-generational homes in close proximity to others, increasing the spread of COVID. ▪ The pandemic exposed how vulnerable many of our social services and systems are.	▪ Some community service providers have lost funding during the pandemic, hampering their ability to deliver services. ▪ There is a lot of misinformation spreading through the community regarding COVID. ▪ Evictions have and will continue to increase as a result of the pandemic. Those behind on rent are falling further behind and will struggle to recover. ▪ Many live in over-crowded housing due to affordability, and are at greater risk of infection. ▪ The pandemic highlighted ongoing inequities in Black and Brown communities, including education and income inequities. ▪ There has been a surge in domestic and neighborhood violence due to the pandemic. ▪ Many parents have been struggling with multiple children learning at home; this exposed the lack of/poor quality internet access for many. ▪ More community health workers are needed to combat misinformation and increase vaccination rates. ▪ "I think it is important to acknowledge that the pandemic also showed the resiliency of the essential workers and support in this community. Our health systems rose to the challenge. Our essential non-profits stayed open and pivoted. This was a great crisis response and is not acknowledged enough!"

Resources Potentially Available to Meet the Significant Health Needs

In all, 877 resources were identified in the service area that were potentially available to meet the identified significant health needs. These resources were provided by a total of 321 social service, nonprofit, and governmental organizations, agencies, and programs identified in the CHNA. The identification method included starting with the list of resources from the 2019 Sacramento County CHNA, verifying that the resources still existed, and then adding newly identified resources to the 2022 CHNA report. Examination of the resources revealed the following numbers of resources for each significant health need as shown in Table 16.

Table 16: Resources potentially available to meet significant health needs

Significant Health Needs (in Priority Order)	Number of Resources
Access to Mental/Behavioral Health and Substance-Use Services	110
Access to Basic Needs Such as Housing, Jobs, and Food	134
Access to Quality Primary Care Health Services	77
System Navigation	60
Injury and Disease Prevention and Management	90
Health Equity: Equal Access to Opportunities to be Healthy	*
Active Living and Healthy Eating	83
Safe and Violence-Free Environment	75
Increased Community Connections	170
Access to Specialty and Extended Care	44
Access to Functional Needs	11
Access to Dental Care and Preventive Services	14
Healthy Physical Environment	9
Total Resources	877

*Note: Most, if not all, resources noted work in some way to reduce or eliminate health inequity.

For more specific examination of resources by significant health need and by geographic location, as well as the detailed method for identifying these, see the technical section of this report.

Impact and Evaluation of Actions Taken by Hospital

Regulations require that each hospital's CHNA report include "an evaluation of the impact of any actions that were taken since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s) (p. 78969)."[18] The statement of impact can be found in Appendix A of this report.

[18] Federal Register, Vol. 79, No. 250, (Wednesday, December 31, 2014). Department of the Treasury, Internal Revenue Service.

Conclusion

This CHNA report details health needs of the Sacramento County community as a part of a partnership between Dignity Health, Sutter Health, and UC Davis Health. It provides an overall health and social examination of Sacramento County and the needs of community members experiencing health disparities. The CHNA provides a comprehensive profile to guide decision-making for the implementation of community health improvement efforts.

Appendix A—Impact of Actions Taken

The 2019 Implementation Plan addressed many of the significant health needs identified in the UC Davis Medical Center's Community Health Needs Assessment (CHNA). The following is an overview of the actions taken since the last CHNA.

Each Significant Need includes a brief description and is followed by the key objectives (in bold) and the activities conducted under each need.

Significant Need #1: Access to Quality Primary Care Health Services

UC Davis Health focused on deploying resources to support the region's community health clinics and patient navigation services (to assist community members with access to healthcare services, coverage and other assistance).

Increasing Access to Primary Care Through Partnerships with the Region's Federally Qualified Health Centers (FQHCs)

Sacramento County Primary Care Center

More than 12 full-time equivalent UC Davis physicians and nurse practitioners and nearly 40 residents from internal medicine, family medicine, pediatrics and psychiatry provide care at the Sacramento County Primary Care Center, a number that has increased significantly over the last three years. Two faculty members from the School of Nursing joined the patient care team in 2020, along with between two and five nurse practitioner/physician assistant students each month.

In FY 2020, the Primary Care Center provided 35,000 visits for Medi-Cal, uninsured, Medicare and refugee populations, representing nearly 11,000 unique patients. Approximately one in four patients were part of the county's Healthy Partners program, which provides primary and preventive health care services to low-income, undocumented adults.

Support from UCDH advances diverse Primary Care Center programming. Examples include:

- Complex Care Coordination Clinic: Fourth year Internal Medicine and Psychiatry residents, and nurse practitioner and/or physician assistant students, oversee the clinic for Health Net/UC Davis Health Medi-Cal members who have complex needs.
- Mental Health Buddy Program: a resident in Pediatrics and a Child Psychiatry fellow are paired to manage the care of children with complex psychiatric illness in the Pediatrics Clinic.
- The Clinic at Loaves and Fishes: Internal Medicine and Family Medicine physicians provide care to people experiencing homelessness, on location at a clinic site established within Loaves and Fishes.
- The Chronic Disease Clinic: Nurse practitioner and physician assistant students outreach to patients with poorly controlled diabetes and coordinate care with primary care nurse practitioner residents in Adult Medicine and Pediatrics.
- Family and Community Medicine: physicians and residents provide whole-family care for patients, including expertise in care for refugee patients and families, and substance use treatment, including Medication Assisted Therapy (MAT) for opioid use disorder, with a concentration for patients who are pregnant, homeless, or medically complex.

- CIRCLE Clinic (Comprehensive Integration of Resilience into Child Life Experiences): An integrated care clinic that provides comprehensive medical care, mental health care and developmental-behavioral screenings to children connected with the child welfare system, in coordination with the assistance of a family navigator. All patients are seen by a mental health therapist and family navigator from the UC Davis CAARE Center and a pediatrician from the Department of Pediatrics at every visit. Young children and children with developmental concerns are assessed by a developmental-behavioral pediatrician from the MIND Institute. All children are offered PC-CARE, a brief parenting intervention developed at the UC Davis CAARE Center.

Partnerships with Additional Sacramento Area Federally Qualified Health Centers
UC Davis Health provides primary care services in the FQHC network in the Sacramento region.

Founded as a clinic to treat persons living with HIV/AIDS, One Community Health is now dedicated to providing comprehensive primary, specialty and behavioral health care. In partnership with the clinic, UC Davis Health infectious disease physicians care for many of the 2,400 people living with HIV in the Sacramento area that are cared for at One Community Health. UC Davis Health also provides faculty physician support through Family and Internal Medicine.

Sacramento Native American Health Center (SNAHC) is committed to enhancing quality of life by providing a culturally competent, holistic and patient-centered continuum of care and by partnering with more than 40 community-based organizations to enhance access to social and other service programs. Through the partnership with SNAHC, Department of Pediatrics faculty and residents see more than 1,600 unique patients. In 2019, UC Davis Health donated $250,000 to support tenant improvements in the development of a new SNAHC clinic in South Sacramento, anticipated to open in 2022.

Elica Health is a network of 11 community health centers in the Sacramento region that provides services for more than 38,000 individuals. From March 2020 – December 2021, the three medical vans and street medicine teams that are part of Elica's Wellness Outside Walls initiative provided more than 8,000 Covid-19 tests, including 644 to adults experiencing homelessness at shelters operated by the City of Sacramento. During this same time period, clinicians on the vans provided 5,487 medical visits to adults and children with Medi-Cal or who are uninsured. In addition to providing funding for the purchase of one of the vans in 2018, UC Davis Health providers serve as clinical volunteers on the mobile clinic and at various community events throughout the Sacramento region.

UC Davis Health also partners with CommuniCare Health Centers, a network of FQHCs operating in Yolo County, that provides comprehensive health care services delivered by a dedicated team of providers and support staff through clinic sites and outreach programs. The Chief Medical Officer is a UC Davis School of Medicine faculty member. Faculty members and residents provide care at West Sacramento, Davis, and Woodland clinic sites.

Support for Programs Training Primary Care Physicians and Other Health Care Providers

The UC Davis Health departments of Internal Medicine, Family and Community Medicine and Pediatrics offer educational opportunities for medical students, residents and post-doctoral professionals, with a focus on providing diverse community training experiences. The Community Health Scholars (CHS) programs at the School of Medicine train medical student leaders to identify, understand, and serve the unique health needs of California's rural, urban and valley communities. Four of these programs are highlighted below:

- Transforming Education and Community Health for Medical Students (TEACH-MS) – this highly successful training program is geared for residents interested in primary care for the urban underserved. The program

seeks to improve access to effective, culturally respectful and equitable health services for underserved communities by providing rewarding community-based experiences that support medical students' interest in primary care.

- Accelerated Competency-based Education in Primary Care (ACE-PC) program – in partnership with Kaiser Permanente, the UC Davis School of Medicine offers an innovative pathway for students committed to primary care careers. ACE-PC allows students complete their MD education in three years, enter a partner residency well-prepared for internship and begin their primary care practices earlier.
- Tribal Health PRIME Community Health Scholars Program – A new academic pathway funded in the 2021 State budget to provide students with the appropriate knowledge and skills to practice medicine in California's urban and rural tribal communities. Students enter after completing a 10-month post-baccalaureate program at Oregon Health Science University that prepares American Indian and Alaska Native students from federally recognized tribes to successfully enter and complete medical school.
- Preparando Estudiantes Para Ser Medicos or Preparing Students to Be Physicians (Prep Medico) – In partnership with Kaiser Permanente, UC Davis Health supports this intensive, six-week residential pipeline program for freshmen and sophomore college students from Northern California or the Central Valley who are interested in becoming physicians and who have demonstrated an interest in serving Latino communities.

Advanced Training for Community Clinicians

UC Davis Health gives tuition scholarships to clinicians from the Sacramento FQHC network to facilitate their participation in three programs that aim to increase primary care providers' ability to care for patients with more complex care needs and share their learnings with their colleagues. From 2019-21, 19 providers from local FQHCs completed the programs described below:

- UC Davis/UC Irvine Train New Trainers Primary Care Psychiatry Fellowship – a year-long clinical education program for primary care-oriented trainees and providers who wish to receive evidence-based, advanced training in primary care psychiatry.
- Train the Trainer: Primary Care Pain Management Fellowship – a 10-month multidisciplinary program that targets the most pressing topics related to comprehensive pain management including prescription drug abuse, responsible opioid prescribing and substance use disorders. Participants gain the knowledge and skills needed to educate their colleagues on the primary care frontline and raise the standard of pain management across their primary care community.
- Provider Wellness - the Clinician Health and Well-being Fellowship – a six-month program that aims to foster the culture of medicine as it relates to clinician health, well-being, minimizing burnout, and strengthening resilience.

UC Davis School of Medicine Student-run Clinics

For more than 35 years, student-run clinics affiliated with the UC Davis School of Medicine have been operating in the Sacramento neighborhoods, providing free health care to uninsured, low-income and other underserved populations. Operating on weekends, these clinics provide culturally sensitive health care in a respectful and comfortable environment. Each clinic is overseen by volunteer physicians and emphasizes care to specific populations, often in partnership with community-based organizations. Undergraduate students act as interpreters, patient advocates, receptionists and lab workers. These clinics provided more than 8,000 patient care visits in FY 2020. To support these visits, the UC Davis Health Pathology Department provided $810,000 in lab services at no cost to patients.

Additional Objectives Discussed Under Other Significant Needs

Two additional objectives for Significant Need #1 are addressed under Significant Need #3 System Navigation to reduce duplication. These are:

- Facilitate referrals to primary care, insurance coverage and other appropriate services
- Increase education of community members regarding access to primary care (includes navigator programs)

Significant Need #2: Access to Mental, Behavioral and Substance Use Services

UC Davis Health focused on deploying resources in community-based settings, supporting initiatives for community members experiencing homelessness, and conducting research on interventions that can be applied in community settings.

Increase Access to, and Quality of, Mental Health Care and Substance Use Disorder Services Through Outpatient Community-based Programs

UC Davis Health's Department of Psychiatry and Behavioral Sciences delivers psychiatry care services at Sacramento County-run facilities, including the Adult Psychiatric Support Services Clinic, Mental Health Treatment Center, the Mental Health Urgent Care Clinic, the Sacramento County Jail, Department of State Hospitals – Napa, and the SacEDAPT Clinic.

- UC Davis Health provides more than 120 full-time or part-time psychiatrists, psychologists, nurse practitioners, and licensed clinical social workers to work at Sacramento County-operated or funded facilities and the Department of State Hospitals – Napa, providing direct behavioral health services. UC Davis Health has nearly doubled its investment since 2018, when 55 staff were providing services.
- UC Davis Health supports the need for critical care in the community by prioritizing community-based residency and fellowship placements. Annually, 22 general psychiatry, child psychiatry, combined internal medicine/psychiatry, and family medicine/psychiatry and forensic residents and fellows rotate through a county facility.

Child and Adolescent Psychiatric Services (CAPS) Clinic

Through a partnership with Sacramento County, UC Davis clinicians and staff provide psychiatric assessments, medication management, psychological testing and mental health services to children and youth who are Medi-Cal beneficiaries. The CAPS Clinic program also provides training to two pre-doctoral and two post-doctoral psychologists working towards specialties in children's mental health.

CA BRIDGE Program

Launched in 2018 and supported with funding through the Department of Health Care Services (DHCS), hospitals that participate in the CA Bridge Program connect people with substance use disorders to Medication-Assisted Treatment (MAT) in the emergency department and link to ongoing treatment at FQHCs in the community. This model of care treats substance use disorders like any other life-threatening illness – by providing lifesaving treatment along with access to care. UC Davis Health was one of the first CA Bridge pilot sites. Most of the prescribers in the UC Davis Emergency Department have a license to prescribe buprenorphine and treat patients with opioid use disorder. Since Jan 2020 UC Davis Health substance use navigators have taken care of more than 5,220 people with substance use disorders. Between January 2020 and November 2021, 857 individuals were started on MAT in the ED and linked to outpatient care.

Early Psychosis Programs (EDAPT and SacEDAPT)

UC Davis Health's Early Psychosis Programs are nationally recognized for early psychosis care and offer expertise in state-of-the-art assessments and evidence-based practices for early identification and intervention for psychotic disorders. Eligible patients and their families receive individualized, comprehensive, multidisciplinary treatment that includes medical and pharmacological treatment, case management, individual and group therapy, substance abuse treatment and supported employment/education. After two years of comprehensive care, patients are transitioned into treatment in community settings.

- From 2019 – 2021, EDAPT and SacEDAPT served 909 individuals and families from diverse backgrounds. Seventy percent of the individuals were on Medi-Cal or had no insurance.
- Approximately 70 percent of participants who complete one of the programs are enrolled in full-time school or have full-time employment, compared to an average of only 20 percent for participants completing treatment in a community setting.

Fostering Secure Placements for Children in Transition Project

UC Davis Health works in partnership with Sacramento County to provide trauma screening and treatment intervention to increase foster placement stability, reduce trauma-related symptoms, and improve referrals for other care needs for children aged 1-5 years old in the foster care system. The brief parenting intervention, Parent-Child Care (PC-CARE), was developed at UC Davis Child and Adolescent Abuse Resource and Evaluation Center (CAARE Center) as a six-session dyadic treatment program for families with children ages 1-5 years old who have entered a new foster placement in the previous 60-90 days that are interested in improving caregiver-child relationships. In fiscal year 2019-2020 and fiscal year 2020-2021, the CAARE Center screened 471 children and provided PC-CARE to 344 children and their caregivers. The same period observed the following outcomes:

- Retention rate – Approximately 70 percent of caregivers agreed to participate in PC-CARE and 80 percent of caregivers and children completed the intervention once they began if CPS kept the child in the same placement during that period.
- Reduced levels of behavior problems – 38 percent of children had clinical levels of behavioral concerns pre-intervention and 14 percent post-intervention.
- Placement stability – the stability of foster care placement one-month post-intervention was 95 percent among those completing PC-CARE compared with 56 percent among those dropping or never starting treatment.

Resources, Education, Advocacy and Counseling for Homeless (REACH) Families

UC Davis Children's Hospital's crisis therapists provide onsite prevention services to homeless children at the Mustard Seed School, Bannon Street Shelter, and Waking the Village. The program works with partners to identify needs of children with social skills, crisis counseling and mental health services, as well as screening for symptoms of trauma. More recently, a family navigator has been added to staff to assist children and families obtain housing and connect with key community services. In FY 2020 and 2021, the REACH Families program served 248 children and families.

Increase Support for Mental, Behavioral and Substance Use Disorder Services Focused on Vulnerable Populations

Interim Care Program (ICP)

The Interim Care Program, a collaboration between the four Sacramento area health care systems (Kaiser Permanente, Sutter Health, Dignity Health and UC Davis Health), Sacramento County and WellSpace Health, provides respite care to ensure patients experiencing homelessness have a safe, clean place to recover from hospitalization. WellSpace Health delivers meals, on-site nursing care and case managers who provide transportation to health and other treatment services, assist with housing placement, and facilitate other assertive community treatment supports. UC Davis Health has provided operational funding since the program's inception in 2005. Between January 2019 and September 2021:

- UC Davis Health referred 870 discharged patients to ICP, approximately 37 percent of whom were admitted to the program. The most common reasons patients were not accepted: lack of available beds or need for a higher level of care. Twenty-eight percent of referred patients were "no shows" and either came and left or declined services.
- Over 80 percent of ICP clients utilized the social services resources and graduate from ICP. Eighty-one percent of clients referred from UC Davis Health reported keeping an appointment with a primary care physician during their ICP stay and 51 percent reported attending a mental health visit.

Bender Court Crisis Program

The Bender Court Crisis Program is a six-bed short-term crisis residential program operated in partnership with Turning Point Community Programs. Bender Court provides support for adults experiencing a mental health crisis, averting the need for psychiatric hospitalization. Participants are offered a safe, short-term, supportive environment with the goal of symptom stabilization. Bender Court services include counseling/therapy, housing assistance, establishing a primary care provider, and connecting clients with benefits.

- From July 2019 through November 2021, 204 individuals were discharged from the program. Some individuals had multiple enrollments/discharges within the reporting period resulting in a total of 242 discharges.
- Of the 242 discharges that occurred, 60 percent of the clients showed marked behavioral health improvements (demonstrated through a significant increase in Milestones of Recovery Scale Score).
- The program received an overall participant satisfaction rate of 90 percent.

Sacramento Mobile Integrated Health (SacMIH)

In 2016, the Hospital Council of Northern and Central California began convening discussions with the Sacramento area health systems and Emergency Medical Services agencies to develop a mobile integrated health model, pairing an advanced level practitioner with a paramedic to respond to behavioral health calls. UC Davis Health provided $325,000 in 2017 to develop and support the program. While the COVID-19 pandemic and administrative challenges delayed the start of the program as it was initially designed, the first SacMIH unit deployed in 2020 to provide COVID-19 testing, primarily in congregate living facilities. UC Davis Health residents from emergency medicine and internal medicine volunteered on the units. Sacramento Metro Fire District officially launched the first SacMIH unit in November 2021, responding to behavioral health calls and proactively contacting high utilizers of the 911 system. The program is expected to begin responding directly to low-acuity 911 calls in early 2022.

Enhance Education of Community Members and Providers Regarding Behavioral Health

Trauma-informed Care Landscape Assessment

Upon completion of the 2019 CHNA, the four Sacramento area health systems convened to identify new opportunities for coordinated investment. Mental health, with specific attention towards trauma-informed practices, was identified as a priority health need. In 2020-21, the health systems commissioned Harder and Company to better understand how community members and providers think about and define trauma-informed and healing-centered practices and provide recommendations on how to support a systems approach that complements and builds on the trauma-informed practices that are already occurring. Findings were presented at a community forum in May 2021 and at the Sacramento County ACEs Network of Care in December 2021. The health systems will continue to engage with ACEs Network of Care participants on the recommendations and prioritizing activities for 2022.

I Got Your Back Project

The goal of the I Got Your Back Project, funded collaboratively by the Sacramento area's four health systems in 2019, is to provide the tools and skills within hospitality industry workplaces to identify and talk about mental health issues in a safe environment that encourages people to seek the help they may need. The framework includes peer-to-peer training, stigma reduction and linking people to community resources. Pilot participating restaurants were recruited in 2019, but the Covid-19 pandemic significantly slowed the creation of an online training curriculum and program dissemination.

Significant Need #3: System Navigation

UC Davis Health focused on supporting community-based organizations that help people access and navigate care and integrate appropriate services within the healthcare and mental health systems.

Improve Appropriate Referrals to Health Care and Other Social Service Supports

Patient Navigation Services in the Hospital

Patient navigation plays a crucial role in improving health outcomes for people who live in under-resourced communities. By addressing inequities, patient navigators can foster trust and connect people to resources.

UC Davis Health has built an internal Health Navigator Program steadily over the past two years. Beginning in 2020, the program now has 15 navigators, including: six navigators operating out of the Emergency Department (including one dedicated to mental health services), six navigators working with patients who have been admitted to UC Davis Medical Center, one who supports both ED patients and patients who have been admitted, and two navigators dedicated to the Children's Hospital. The navigators provide in-person help for patients who need assistance with post-discharge care coordination needs, and follow-up by telephone for 30 days. Services include scheduling primary care and specialty follow-up appointments, coordinating transportation to appointments, signing up for electronic health records, and making referrals to community-based organizations. Between January 2021 and November 2021, the Health Navigator Program had more than 12,750 patient encounters. In January 2022, the Health Navigator program expanded into additional inpatient services, including patients from the trauma department and surgery. UC Davis Health navigators also work closely with navigators from Sacramento Covered, Health Net, River City Medical Group and Bay Area Community Services.

In addition, UC Davis Health substance use navigators provide critical substance use services in the hospital. Certified drug and alcohol counselors in the hospital customize treatment plans for patients and connect patients with local programs and resources (including through the CA BRIDGE Program described above). Between January 2020 and November 2021, substance use navigators had 5,221

patient encounters.

Sacramento Covered

Sacramento Covered, a community-based organization focused on improving the overall health of residents in our region, works to increase understanding of healthcare issues amongst the people who are uninsured, educate residents about healthcare options, and help people overcome barriers to coverage. Since 2015, UC Davis Health has funded a patient navigator in the emergency department to provide onsite assistance to patients. UC Davis Health added a second navigator who provides desk support from Sacramento Covered offices in 2019. The navigators support patients to connect and/or reconnect with their primary care provider, assist in determining eligibility for patients with no insurance coverage, and facilitate other public benefits and access to resources.

In FY 2020 and FY 2021, 3,400 patients were referred to and/or identified by Sacramento Covered navigators for assistance. Sacramento Covered was not able to provide in-person coverage in the emergency department from March-June 2021 due to Covid-19 protocols, which ultimately impacted the program's ability to connect with patients. Although the number of referrals was slightly higher in FY 2021, in FY 2020, 78 percent of patients received education or help making an appointment and in FY 2021 this decreased to 53 percent. Sacramento Covered navigators also work with some of the more complicated and time-consuming patient issues, including helping Medi-Cal managed care members when they need to change health plans or primary care provider, transfer Medi-Cal coverage between counties or coordinate dental services that require anesthesia.

UC Davis Health also provides ongoing financial support for Sacramento Covered operations. The Sacramento Covered team of health access specialists and community outreach workers provide in-person assistance to families across five counties, 15 neighborhoods and in 13 languages.

Enhance Access to and Coordination of Care Through Community-based Efforts

Sacramento County Primary Care Center

UC Davis Health worked in partnership with Sacramento County to bolster resources to address the social determinants of health, including increased connection to housing, food, immigration services, insurance coverage and enrollment to social supports. Between June 2019 and August 2020, 429 patients were served by Sacramento Covered on site at the Primary Care Center, receiving education about their eligibility for public insurance programs, and assistance with signing up, if appropriate. Due to the pandemic, many of the on-site services were on hold for much of 2020 and parts of 2021.

Increase Support for Services Focused on Populations Who Experience Physical, Emotional, Social and Economic Vulnerability, Including People Experiencing Homelessness

Pathways to Health + Home

The Pathways to Health + Home (Pathways) program, the Medi-Cal Whole Person Care pilot operated by the City of Sacramento, was a five-year pilot to improve the health, quality of life, and housing stability for individuals experiencing homelessness. Participants included health systems, health plans, FQHCs, housing and homeless service providers, first responders, law enforcement, and community-based

organizations. In addition to health care services, Pathways provided clients with outreach and navigation services, service coordination, case management, housing support services, and respite care. Through May 2021, UCDH referred 1,069 patients to the program, 376 of whom were ultimately enrolled (approximately 43 percent of patients referred could not be reached post-referral and 15 percent of patients referred declined to participate). Referrals from the health systems ended May 30, 2021, as the program began to ramp down services, and the program ended December 31, 2021.

In total the program provided more than 390,000 face-to-face services to more than 2,300 people, 969 of whom were successfully connected to housing (as of July 2021). An evaluation of the program from July 2019-June 2021 of 510 disenrolled participants for whom utilization data was available showed a 42 percent decrease in inpatient admissions and 26 percent decrease in emergency department visits when comparing healthcare use six months pre- and six months post-participation.

Triage Navigator Program (TNP)

In partnership with Sacramento County and Hope Cooperative, the Triage Navigator Program serves individuals who are experiencing a mental health crisis resulting in functional impairment that interferes with primary activities of daily and independent living. Triage Navigators are placed in hospital emergency departments, including UC Davis Medical Center, as well as the county jail and Loaves and Fishes, to assist patients in accessing outpatient mental health services and resources. From July 2020-June 2021, Hope Cooperative received 1,869 referrals and screened 660 clients, who were referred to a peer navigator. These numbers are inclusive of the time the program was ramping down in Q2 2021. Outcomes of note for July 2020-June 2021 include:

- An average 30 percent reduction in hospitalizations for individuals enrolled in TNP and linked to ongoing mental health care when comparing the time before being screened for the program and after discharge (compared to people who were not linked to ongoing care).
- An average 51 percent reduction in referrals from emergency departments to the Sacramento County Mental Health Treatment Center intake stabilization unit due to navigator assistance helping clients connect to ongoing care.

Significant Need #4: Injury and Disease Prevention and Management

UC Davis Health supported initiatives that expanded the knowledge of community members, programs that improve disease prevention and management, and research on disease and injury prevention.

The COVID-19 pandemic exacerbated existing challenges many community members faced and, as key informants and focus groups noted in the 2022 CHNA, caused many people to avoid preventive care (e.g., immunizations, wellness visits, screenings) due to fear of exposure to COVID-19. Addressing COVID-19 emerged as a key objective for UC Davis Health, including through testing, vaccination and supporting community organizations and residents.

Addressing COVID-19

Ambulatory Care Operations at UC Davis Health and several community partners administered tens of thousands of vaccines when the COVID-19 shot became widely available at the beginning of 2021. The UC Davis School of Medicine used zip code data provided by the California Department of Public Health (CDPH) to identify neighborhoods with lower vaccination rates or who lacked access to accurate, culturally competent information. UC Davis School of Medicine faculty, staff, residents and students connected with community partners, including Cristo Rey, La Superior grocery stores, festivals, churches, schools, farmers markets and the River Garden apartment complex to launch pop-up clinics. From August – November 2021, the School of Medicine mobile team provided an excess of 800 volunteer hours to community vaccination efforts and hosted 22 mobile clinics in under-resourced areas of Sacramento. The Center for Reducing Health Disparities also received a grant in late 2021 that focuses on community-based strategies to increase testing access and vaccine uptake by Latinx and African Americans in Sacramento and Yolo counties. As of January 2022, the project has administered 1,562 doses of vaccine in partnership with 14 different locations.

The Joan Viteri Memorial Clinic, a student-run clinic associated with the School of Medicine, was the lead COVID-19 testing partner for Sacramento County Public Health at encampment sites in Sacramento County. From May 2020 through February 2021, the partnership administered 946 tests.

In May 2020 UC Davis Health and the other three Sacramento area health systems provided financial support to Sacramento Steps Forward (SSF) to facilitate the referral of patients experiencing homelessness to temporary housing, including COVID-19 quarantine or isolation shelters. SSF is the lead agency for Sacramento's Continuum of Care, the regional planning body that coordinates housing and services for individuals and families experiencing homelessness in Sacramento County. The collaborative effort came together quickly and allowed SSF to add additional staff during the early months of the pandemic response.

During the pandemic, existing structural inequities were exacerbated, and food security was a prominent health challenge for under-resourced populations highly impacted by COVID-19. UC Davis Health partnered with local organizations to fund, organize and distribute grocery programs throughout our community. Two examples of these programs included Food for All – a grocery distribution partnership with Asian Resources, Inc. (ARI) focused on addressing COVID-19-aggravated food insecurity among Asian communities in South Sacramento – and The Pantry, an annual food drive put on by the Latinx Staff Faculty Association to address food insecurity in surrounding communities.

UC Davis Health also provided funding and 500 KN95 masks to Sacramento Covered in April 2020 to support their provision of daily meals to Pathways/Whole Person Care participants and other community members experiencing homelessness.

Additionally, the Center for Healthcare Policy and Research, the Center for Health and Technology and the Behavioral Health Center of Excellence at UC Davis united to fund a range of research on the impact of COVID-19. The funding is committed to five projects that explore the effects of the pandemic on mental health, breast cancer screening, NICU care, children with disabilities and post-surgery therapy.

Increase the Use of Safety Equipment and Knowledge to Prevent Childhood Injuries

Trauma Prevention and Outreach Programs

The Trauma Prevention and Outreach Program at UC Davis Health is dedicated to preventing and reducing injuries through the strength of community partnerships. By combining injury surveillance data from local and regional sources with input from community partners, the program identifies leading causes of injuries impacting communities in the Sacramento Region. The program works with a wide array of organizations to implement evidence-based injury prevention programs to improve safety across the age continuum.

Programs include:

- Child Passenger Safety Program – The Child Passenger Safety Program addresses the transportation safety needs of children and families in the Sacramento region. In collaboration with community partners, the program provides no-cost car seats, car seat education classes, installation events and inspection stations for parents and caregivers. Parents and caregivers participated in car seat classes that provided comprehensive instruction in English or Spanish on how to properly install and use child safety seats. Classes were held in person during 2019 then provided virtually during 2020-2021. During 2019-2021, the program provided more than 900 free car seats to families and completed more than 1,000 free car seat inspections.
- Helmet Safety Program – The Helmet Safety Program focuses on increasing helmet use among children who ride bikes, scooters, skateboards, and skates. Working with 37 school districts, family resource centers and health clinics throughout Sacramento, the Helmet Safety Program provided educational programs and free helmets to underserved children through community partner helmet safety centers. More than 8,410 students and families received helmet and traffic safety education and more than 550 helmets were distributed during 2019-2021. In 2021, the program established a new partnership with the American River Bike Patrol to provide free bicycle helmets to families using the American River Bike Path.
- Every 15 Minutes – Every 15 Minutes is a program that focuses on the risks associated with underage drinking. The two-day program designed for high school juniors and seniors, challenges students to think about drinking, driving, personal safety, the responsibility of making mature decisions, and the impact of decisions on family and friends. UC Davis Health has been actively involved since 1997. UC Davis Health provides in-kind support through volunteer nurses, physicians, respiratory therapists, and clinical pastoral services.
- Impact Teen Drivers - In January 2018, UC Davis Health began a new partnership with Impact Teen Drivers that focused on California's leading cause of youth injuries – motor vehicle traffic accidents. Injury prevention staff and nurse volunteers provide educational workshops for Sacramento area high school students about safe driving, utilizing the evidence-based curriculum, "What Do You Consider Lethal?"
- Wraparound Program – The Wraparound Program is a free service for UC Davis Health patients between the ages of 13-26 years who were injured by interpersonal violence. The program extends care of youth and young adults who are violently injured beyond the hospital, to support long-term healing and recovery. The program uses nationally certified Violence Intervention Specialists (VIS) to provide relationship-based mentoring, referrals to culturally affirming mental health services, and intensive, individualized case management to support physical, mental and emotional recovery. During 2019-2021, Wraparound provided comprehensive support for 50 youth who had been violently injured.
- Matter of Balance - A Matter of Balance (MOB) is a program designed to reduce the fear of falling and increase activity levels among adults who are older and less active. MOB includes 8 two-hour weekly sessions for a small group of 8-12 participants led by a trained facilitator. The Trauma Prevention Program offers free MOB workshops to seniors in the Sacramento Region. In 2019, more than 40 older adults participated in the UCDH MOB program, for a total of 640 program hours.

UC Davis Children's Hospital Passenger Safety Program

UC Davis provides a free car seat to all UC Davis Children's Hospital patients in need, including infant carriers for newborns and replacement seats for pediatric patients involved in motor vehicle collisions. During 2019-2021, the program provided more than 1,000 free car seats for pediatric patients being

discharged from the hospital. Staff also provides ongoing education to nurses and physicians on current laws, best practices, and hospital resources for child passenger safety. The program partners with Occupational Therapy to assess pediatric patients with special transportation needs and provide families with a specialized loaner car seat when needed.

University of California Firearm Violence Research Center

The University of California Firearm Violence Research Center at UC Davis is a multidisciplinary program of research and policy development focused on the causes, consequences and prevention of violence. Past work includes research on the social conditions that underlie violence, and they have created the BulletPoints Project, which gives clinicians specific strategies they can use in their clinics to reduce firearm injury and death. The Center received additional State funding in 2020 to expand its research and develop comprehensive training for a wide range of California providers, including physicians, mental health care professionals, and advance practice clinicians.

Increase the Knowledge of People Who Are at a High-risk of Living with a Chronic Disease on Ways to Manage Chronic Diseases

UC Davis Comprehensive Cancer Center

The UC Davis Comprehensive Cancer Center is the only National Cancer Institute-designated center serving the Central Valley and inland Northern California. The Center specialists provide comprehensive care for more than 100,000 adults and children every year, and access to more than 200 clinical trials at any given time. The Center also maintains a dynamic Community Advisory Board (CAB) comprised of nine non-academic/non-UCD leaders from the 19 inland northern California counties that are home to 90 percent of the Cancer Center's patients. The CAB provides invaluable insight from patients and patient families that is integrated into quality assurance and quality improvement efforts.

During 2020 and 2021, the Cancer Center's Office of Community Outreach and Engagement conducted 55 cancer prevention events reaching almost 5,000 people. These events include participation in health fairs, speaking engagements, community workshops and trainings for health care professionals. Topics covered cancer screenings, modifying behavioral risk factors for cancer, and addressing cancer health inequities in diverse populations. Additionally, partnerships were developed with 20 new organizations to promote cancer prevention and control, and to assist in COVID-19 outreach events for the Latino community.

The Cancer Center also partnered with the Health and Life Organization, a Hmong-led FQHC look-alike in Sacramento, to implement evidence-based, culturally respectful interventions that resulted in 2,683 patients who are Asian American and Pacific Islander getting screened for breast, cervical, and colorectal cancer, and hepatitis B (HBV). The project included electronic health record enhancement, bilingual and bicultural Hmong/English case managers to provide culturally competent care and link patients to specialty care, a medical assistant training academy, and HBV education workshops for patients.

Through partnership with Northern Valley Indian Health, the Cancer Center increased human papillomavirus (HPV) vaccine initiation (from 52.4% to 82.7%) and completion (27.0% to 58.0%) rates among adolescent patients of the rural Willows Community Clinic. The multilevel intervention facilitated by parents, primary care teams, and clinics was guided by evidence-based approaches to increase HPV vaccinations, formative research, and input from the community.

The Cancer Center is also home to Latinos United for Cancer Health Advancement (LUCHA), which aims to increase knowledge and awareness about cancer prevention among Latino populations in California while increasing participation in early detection screenings and clinical trials. In 2020, LUCHA began hosting

Charlas en Español Entendiendo el Cáncer en Latinos, free, virtual forums, conducted in Spanish, to provide basic educational information about cancer and spark a conversation so that experts can answer questions in real-time from participants.

Continuing Medical Education
UC Davis Health's Office of Continuing Medical Education develops and delivers comprehensive and innovative educational activities for all health care professionals. In addition to CME events and courses, the Office hosts a regularly scheduled webinar series and provides course development services. From 2019-21, the Office of Continuing Medical Education sponsored over 600 conferences, workshops, and online courses throughout California. Free classes available to community providers included Preventing Firearm-Related Injury and Death, Medication-Assisted Treatment – a series produced in conjunction with the California BRIDGE program, Pediatric Acute Care Education Sessions (PACES) for community hospitals, and UC Quits – a series focused on evidence-based tobacco treatments.

Provide Resources for Community Providers and People Experiencing Cancer-related Illness, Asthma and Diabetes

Support For Local Cancer, Cardiac, Asthma and Diabetes Nonprofit Organizations
UC Davis Health funds local nonprofit organizations that provide health education and outreach programs in the Sacramento region including the American Cancer Association, American Diabetes Association, BREATHE California, Juvenile Diabetes Research Foundation and Triumph Cancer Foundation.

Significant Need #5: Active Living and Healthy Eating

UC Davis Health supported initiatives that expanded the knowledge of community members in the region and provided direct support to community organizations addressing food insecurity.

Promote Access to Healthy Food Choices, Including Through Farmers Markets and Food Banks

Support For River City Food Bank
As Sacramento's oldest, continuously operating food bank, River City Food Bank's mission is to alleviate hunger in Sacramento County by providing emergency food and other assistance, offering referrals and promoting self-sufficiency. More than 600 families are served each week at the St. Matthew's Church location in the Arden Arcade neighborhood, through a grant awarded by UC Davis Health in July 2019. The three-year grant has allowed the food bank to expand internal operations, diversify food choices (including halal meats) and increase capacity to provide food to more people, many of whom are recent immigrants to Sacramento. River City Food Bank uses a farmer's market-style experience for guests to select foods that best meet their needs.

Oak Park Farmers' Market
The Oak Park Farmers' Market features a diverse group of vendors selling locally produced and delicious fruits and vegetables, specialty plants and sprouts, breads, cheese, tamales, fresh flowers and more. In addition, the market also provides a variety of interactive activities each week, including live music, activities for children, and information from area non-profits. UC Davis Health provides ongoing financial support for the market's general operating budget. In 2020 and 2021, UC Davis Health physician and staff volunteers also hosted COVID-19 vaccine pop-up clinics at the market to provide vaccinations and education to market visitors.

Elmhurst-Med Center Community Garden

The Elmhurst-Med Center Community Garden includes 24 plots, an herb garden and fruit trees. UC Davis Health staff and students utilize plots to grow vegetables and donate the produce to local food banks and other nonprofits, including the neighboring Ronald McDonald House. Local neighbors have access to half the plots to grow produce.

Increase Knowledge and Skills That Promote Healthy Lifestyles and Healthy Food Choices for Children and Families

The Farmers' Market at UC Davis Health

The Farmers' Market at UC Davis Health was created to provide access to local, fresh fruits and vegetables to patients, staff, students and neighbors close to the UC Davis Health campus. UC Davis Health staff members provide wellness information and health-related activities at the market. The market accepts Cal-Fresh payments, and vendors donate produce to help supply the student food bank on the UC Davis Health campus. In 2020 and 2021 operations at the UC Davis Health campus were suspended due to the coronavirus pandemic and services were moved to the Oak Park Farmers Market at McClatchy Park to assist local community members with easier access to fresh foods.

Dietician Community Outreach and Education

UC Davis Health participates in activities and events that encourage and promote healthy eating. From speaking at community events to participating at health fairs, UC Davis Health's nutrition program provides education throughout the Sacramento region, including a presentation with UC Davis Health's Executive Sous Chef at the City of Sacramento's annual Farm to Fork Festival. Dieticians also participate in radio interviews and contribute articles to popular magazines and academic publications.

Research on Active Living and Healthy Eating

Obesity, and the resulting health consequences, are influenced by behaviors such as dietary patterns, physical activity, the food and physical activity environment, and nutrition education. The Koa Family Program study led by the UC Davis Center for Healthcare Policy and Research is one example of community-oriented, participatory research on healthy lifestyles conducted at UC Davis Health.

The Koa Family Program recruited 70 SNAP-Ed eligible mothers in Sacramento in 2021 to develop and test an obesity prevention program. The intervention group participated in a 17-week whole health program that included weekly, small group online meetings with a health coach; supportive social media including a private Facebook group and selective text messaging; and exposure to community tree planting and stewardship. Session topics included nutrition, physical activity, and related lifestyle and environmental factors that are known to impact weight, such as resilience, social connection, and an environment with adequate tree canopy. The Koa Family Program delivered to the intervention group was associated with significant weight loss, increased physical activity and other favorable improvements in lifestyle and healthful behavioral metrics in spite of population-level, pandemic-associated stressors such as higher mental health burdens and increased weight. The study also highlighted the broad application of tele-wellness as part of a community-based recruitment and intervention program in the midst of the COVID-19 pandemic. More than 80 percent of intervention group participants strongly agreed with the statements, "I feel healthier due to the Koa Family Program" and "the Koa Family Program was worth my time".

UC Davis Health also identified increasing physical activity among children and their families as a key objective but did not have focused efforts in this area with the exception of the Koa Family Program.

Significant Need #6: Cultural Competence

UC Davis Health supported practices that removed barriers and improved access for patients accessing care at UC Davis Health.

Build Partnerships with Community Organizations and Members Research Ways That Ensure Culturally Competent Care in Health Care Delivery

Clinical Translational Science Center (CTSC)

The CTSC serves as a catalyst to support biomedical research projects by providing services and resources to investigators, staff, scholars and trainees, and community partners. The Center promotes the integration of special and under-resourced populations in translational research across the human lifespan, as well as training and cultivating the workforce. The CTSC also facilitates better health among under-resourced rural communities through the establishment of strong community partnerships to advance healthcare access and community-based participatory research. In June 2021, the CTSC received notice of its third, five-year National Institute of Health (NIH) award renewal.

The COVID-19 pandemic highlighted CTSC's impact on clinical and translational science at UC Davis. In 2020, the Center pivoted to provide specialized support to research teams conducting studies on coronavirus. The CTSC enhanced access to digital health data, helped recruit participants, provided regulatory support and implemented protocols for many of the COVID-related clinical trials.

Vietnamese Mini Medical School

As part of UC Davis Health's 20-year long program that offers free classes to the public, the May 2021 Vietnamese Mini Medical School (VMMS) was a bilingual educational community outreach effort sponsored by the CTSC and the UC Davis Alzheimer's Disease Research Center. The event focused on the health of older Vietnamese refugees and immigrants and that of their caregivers – providing trusted medical information on major chronic health conditions affecting older people's brain, heart and mental health. UC Davis Health worked in collaboration with Asian Resources, Inc. to spread awareness of the VMMS. Nearly 100 Vietnamese-American community members participated in the event (virtually), where information was translated into Vietnamese and English in real-time. Another VMMS is expected to take place in-person, May 2022.

Center for Reducing Health Disparities

The mission of the UC Davis Center for Reducing Health Disparities is to promote the health and well-being of diverse communities by taking a multidisciplinary, collaborative approach to the inequities in health access and quality of care. The center's wide-ranging focus on health disparities includes projects focused on improving access, detection and treatment of mental health problems within the primary care setting and achieving a better understanding of the co-morbidities of chronic illnesses. The center also held a three-part virtual symposium in July through September 2020 that explored trauma-informed care and identified key recommendations and best practices for providing services to underserved populations, specifically immigrant families.

CRHD is the technical assistance provider for seven organizations that are conducting pilot projects as part of the California Reducing Disparities Project, a statewide prevention and early intervention effort to reduce mental health disparities in underserved communities. These seven projects focus on implementing culturally and linguistically responsive, evidence-based, community-defined practices and strategies to improve outcomes. In Sacramento, the center is working with La Familia Counseling Center, Inc., which provides multicultural counseling, outreach and support services to help families overcome adversity,

become empowered and succeed in their lives.

UC Davis Center for a Diverse Healthcare Workforce

The Center's mission is to lead research focused on recruiting, training and retaining a diverse health care workforce to advance health equity, educational opportunities and diversity within the healthcare workforce. The Center's research focuses on the health care workforce needs unique to under-resourced communities in rural, tribal, urban and other communities, and its impact on patients, communities and populations. In 2019 the Center was awarded funding to develop the California Oregon Medical Partnership to Address Disparities in Rural Education and Health (COMPADRE), a multifaceted program that aims to reduce health inequities by transforming the physician workforce to be better prepared, more equitably distributed and more deeply connected to under-resourced communities. COMPADRE will place hundreds of medical students and resident physicians to train at 10 health care systems, 16 hospitals and a network of FQHC partners throughout Northern California and Oregon.

Train Staff Within the Health System
Ensure Effective Communication and Language Access

Health Equity, Diversity and Inclusion Efforts within the Health System

The UC Davis Office of Health Equity, Diversity, and Inclusion (HEDI) and its collaborating partners created the Growing as a Community webinar series in 2020 to focus on the important issues of structural racism, strategies and techniques for questioning and interrupting discrimination, and ways to help build healthier and safer inclusive communities. In addition to the 14 webinars conducted in 2020 and 2021, nine webinars were held as part of a special COVID-19: Coping as a Community series.

UC Davis Health also hosts a monthly Diversity and Inclusion Dialogue series open to faculty, staff, students and community members to learn about and discuss issues critical to cultural humility, health equity and diversity/inclusion. Beginning in 2018, UC Davis established racial healing circle discussions that are open to all faculty, staff and students, as well as members of neighboring communities. Subsequently, a cadre of UC Davis Health staff and community members were trained on how to lead racial healing circles, which teach techniques for proactively building authentic relationships.

In 2019, UC Davis Health also implemented a new curriculum for faculty to address cultural bias in the learning and clinical environment. UC Davis Health participates in community activities such as the annual Improving OUTcomes Conference, which explores how health professionals and community partners can improve quality of and access to care for lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) patients and their families and is developing a transgender health learning module for medical students.

Significant Need #7: Access to Specialty and Extended Care

UC Davis Health supported initiatives and programs that improve access to specialty care.

Expand Access to Specialty Services in Community-Based Settings Through Partnerships

Specialty Services in Community Health Clinics

UC Davis Health's growing team of specialists at the County of Sacramento Primary Care Center is deepening the range of services available to patients who are on Medi-Cal, uninsured or underinsured. UC Davis Health and the county expanded services in the last two years to include specialty care such as

women's health, rheumatology, sports medicine, cardiology, nephrology and musculoskeletal disorders. While onsite care at the clinic was limited for a time during 2020 to help minimize the spread of COVID-19, clinicians were able to continue providing telephone and video consultations with patients and primary care physicians before returning to a mix of in-person and telephone visits in June 2020.

Provide Care and Services to Underinsured and Uninsured Community Members

Sacramento Physicians' Initiative to Reach out, Innovate and Teach (SPIRIT)

The SPIRIT Program meets the healthcare needs of the community by recruiting and placing physician volunteers to provide free medical services to people who live in the region who are uninsured. A collaborative partnership of the Sierra Sacramento Valley Medical Society, Kaiser Permanente, Dignity/ Mercy Healthcare, Sutter Health, UC Davis Health and Sacramento County, SPIRIT coordinates specialty consults and surgical services for individuals who are uninsured at local hospitals and ambulatory surgery centers. Patients are referred from a medical home, including patients who visit the UC Davis medical student-run clinics. In addition to funding annual operating support for the program, UC Davis Health began providing gastroenterology procedures to SPIRIT patients at no cost in July 2019. Between July 2019 and September 2021, UC Davis Health provided care to 98 patients, continuing to safely provide this important service during the COVID-19 pandemic.

Additional Investments that Address Community Health Needs

UC Davis Health is continually working to address health needs that impact the community through a variety of means. Efforts include:

Charity and Uncompensated Care

UC Davis Medical Center and its faculty physician practice group have long provided a significant amount of financial assistance (charity care), subsidized care and services for patients on Medi-Cal, and for other patients when reimbursement doesn't cover costs. In FY 2020, UC Davis Health provided $8.2 million in financial assistance and had a $198.2 million Medi-Cal shortfall.

Research

With more than 1,000 basic, translational and clinical studies underway, UC Davis Health is actively exploring the underlying cases of disease and illness, including the socioeconomic factors that influence health conditions. Researchers at UC Davis Health also lead or participate in dozens of studies and clinical trials for COVID-19 therapies and preventions, from monoclonal antibody treatments to the Pfizer-BioNTech vaccine. With more than $276 million in external research funding, the UC Davis Institute for Population Health, UC Davis MIND Institute, UC Davis Comprehensive Cancer Center, UC Davis Institute for Regenerative Cures and others are all leaders to help improve lives and transform health care.

Employee, Faculty and Student Engagement

Employees participate in direct service to the community by donating time, goods, and professional services to nonprofit organizations such as food banks, foster youth programs, schools and shelters for people experiencing homelessness. Many of the volunteer activities, such as the emancipation baskets donated each December, have evolved into annual traditions. Staff and faculty in departments throughout UC Davis Health provide emancipation baskets containing new household and personal items (including kitchen and bath items, and gift certificates for groceries) to young people transitioning to independent housing. The baskets are distributed to youth in the foster care system by social workers in the community. Each year UC Davis Health donates more than 100 baskets.

Community Financial Support

UC Davis Medical Center has a formal sponsorship process in place to accept, review and award funding to local nonprofit organizations that meet the institution's criteria. In recent years, more than 200 organizations have benefitted from the medical center's commitment to the nonprofit sector, with more than $500,000 in direct financial support underwriting health and social service programs. In 2019, UC Davis Health provided $1.4 million to the City of Sacramento to keep the winter shelter open during the winter.

UC DAVIS HEALTH

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22-0220 (5/22)